The Dissertation Committee for David Howard Johnson Certifies that this is the approved version of the following dissertation:

A Structure by No Means Complete:

A Comparison of the Path and Processes Surrounding Successful Passage of Medicare and Medicaid under Lyndon Baines Johnson and the Failure to Pass National Health Care Reform under William Jefferson Clinton

Committee:

Diana M. DiNitto, Supervisor

Barbara W. White

King E. Davis

Kirk von Sternberg

Michael D. Forster

A Structure by No Means Complete:

A Comparison of the Path and Processes Surrounding Successful Passage of Medicare and Medicaid under Lyndon Baines Johnson and the Failure to Pass National Health Care Reform under William Jefferson Clinton

by

David Howard Johnson, M.S.W., B.Mus.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

August, 2009

Dedication

Dedicated to
the memory of the unknown 54,000 Americans
who died for lack of health insurance in the two years
it took me to write this dissertation

and

to the hope of a better tomorrow for the 47 million Americans
who will lay down to sleep tonight in the greatest country on Earth
without the blanket of health insurance protection.

Acknowledgements

To stand on the shoulders of academic giants was my dream when I came to the University of Texas. I have lived that dream. I am beyond grateful to my committee, and especially my supervisor, Diana DiNitto, who has survived the process alongside me. I am particularly glad to have learned under the leadership of Dean Barbara White, who also served on my committee. King Davis has provided extraordinary wisdom and stimulating discussion. Kirk von Sternberg, under whom I also worked at the Health Behavior Research and Training Institute, has been a true mentor and a supportive friend. The faculty at the University of Texas at Austin School of Social Work are unparalleled, and I consider myself fortunate to have been tutored by so many of them. I also thank Dr. James Galbraith of the Lyndon Baines Johnson School of Public Affairs who taught me several exciting new ways to think about public policy.

I also stand on the shoulders of the faculty of the University of Southern Mississippi Department of Social Work. The Dean of the College of Health, Mike Forster, was Director of the School of Social Work when I was a student there. He has been a faithful member of my dissertation committee, and a constant friend since 2005. Joyous Bethel and Ray Scurfield of that faculty have been avid supporters through this trying process. I would not have survived without their love, care, and attention.

I have stood on the shoulders of family as well – family of birth and family of choice. My parents, Howard and Willa Dean Hood Johnson, have been daily companions on this journey if only by telephone. Their sacrifice paid for my first degree and set the stage for this one as well. My brothers and their families have maintained an active interest in my academic shenanigans. They have helped keep me sane. Family of choice members include Charles L. “Chip” Maxey III of Houston, Texas, my closest friend for many years. Chip has supported this effort in every conceivable way, and its completion is a tribute to his patience and care. Robert and Cheryl Sims of Coral Springs, Florida are the friends I have known the longest. Robert taught me most of what I know about the health insurance business. They have frequently posted my grades on their refrigerator as if I am one of their own. I know that I am. Rose March of Belmont, Massachusetts, believed in me when I could hardly drag myself out of bed six years ago. She still believes in me, and tells me constantly. Her love has been a sustaining influence for so long that I know I could not breathe without it.

Finally, none of this work could have been accomplished had it not been for the archivists who have prepared and maintained the files over the years at the Lyndon Baines Johnson Presidential Library and Museum, The William Jefferson Clinton Presidential Library and Museum, and The Wilbur Mills Archives at Hendrix College in Conway, Arkansas. Many of them assisted me by dragging out boxes, making copies, helping me take pictures of the documents, and just generally being helpful. They informed me of their rules and enforced them gently. They rose to every request with grace and professionalism. I thank them for their every kindness.

A Structure by No Means Complete:

A Comparison of the Path and Processes Surrounding Successful Passage of Medicare and Medicaid under Lyndon Baines Johnson and the Failure to Pass National Health Care Reform under William Jefferson Clinton

Publication No._____

David Howard Johnson, Ph.D.

The University of Texas at Austin, 2009

Supervisor: Diana M. DiNitto

In this comparative policy development analysis, I utilize path-dependence theory and presidential records to analyze President Lyndon Johnson's success in passing Medicare and Medicaid and President Bill Clinton's failure to pass national health care reform. Findings support four major themes from the Johnson administration: 1) President Johnson had a keen understanding of the importance of language in framing debate; 2) He placed control of the legislative process in the hands of a small, select group of seasoned political operatives and career policymaking professionals; 3) He paid considerable attention to the details of negotiations and the policy consequences; and 4) He had a highly developed sense of the political and legislative processes involved in passing major legislation. The case study of the Clinton administration reveals five major

themes: 1) There is a lack of evidence that President Clinton remained actively engaged throughout the policy development and legislative processes, instead choosing to delegate the process to the First Lady; 2) There was a naiveté on the part of the Clintons and many administration staff members with regard to the legal and political ramifications of their decisions; 3) The Clintons tried to make the plan fully their own, sharing little credit for its development with Congress; 4) Their attempts to incorporate existing corporate health care delivery structures with their vision for universal coverage proved unworkable; and 5) The extended time from task force launch to bill delivery gave opponents ample time to marshal their opposition forces. I conclude that in developing health care legislation, Johnson had the advantages of: 1) a small group of key policymakers; 2) multiple, simultaneous legislative initiatives which diffused the attention of a more limited media; and, 3) national crises which promoted an environment conducive to sweeping policy change. I suggest that major, national health care reform will not occur until: 1) an economic or geopolitical crisis sets the stage for change; 2) business interests and progressive interests find common ground; and, 3) Americans achieve a new cultural understanding of universal health care as both economically just and economically necessary.

Table of Contents

List of Tables

List of Figures

Chapter 1:
Sick of Being Uninsured

Imagine the scene: The United States, the oldest functioning democracy and one of the wealthiest nations on Earth, faces a health care crisis. Although employer-based coverage is the backbone of the system, tens of millions of Americans still have no access to health insurance, and medical costs are increasing. Despite the crisis, members of Congress have bowed to pressure from business and special interest groups and blocked almost all attempts to reform the health care system.

Onto the stage steps the President of the United States, a tall southerner by birth from a conservative state. He is a Democrat by party affiliation, and his party controls both houses of Congress. He is a charismatic leader, a master of political persuasion not above changing his positions to match the times, yet not without his insecurities. Elected multiple times at the state level, he wins his first national election by an ultra-slim margin. In his inaugural address, he would say "In a land of healing miracles, neighbors must not suffer and die untended" (Woolley & Peters, 2007).

If it sounds like Bill Clinton had his hands full in 1993, he did. But the preceding description is of Lyndon Baines Johnson, 36th President of the United States, who would win his second national election, and first Presidential election, by what has often been termed the "liberal landslide of 1964." Despite facing obstacles that had plagued previous presidents with ambitions to reform the health care system, he pressed for and achieved passage of the Social Security Amendments of 1965. These amendments instituted Medicare and Medicaid, programs that have provided health coverage for millions of aged and impoverished Americans since 1966.

Federal health policy found its beginnings a century ago with the passage of the first Workers' Compensation laws in 1908, offering workers at least minimal protection in the event of work-related injuries. The drive toward national health insurance began soon after in 1912, led by the American Association for Labor Legislation (AALL) and initially supported by the National Association of Manufacturers and the American Medical Association (Weathers, 2004). While the AMA eventually withdrew its support for a national health care plan, social workers were there during the early days of the progressive movement (Brosco, 1994; Poen, 1979), actively worked with the AALL (Kreader, 1988), and have remained actively interested in and supportive of an expanded federal health policy ever since (Hoffman, 1996; Kim, 1990; Millner, 1991). Over the course of the 20th century, the country also saw two major presidential efforts to institute federal health care policies. The first effort resulted in success with the passage of the Social Security Amendments of 1965 under President Johnson, bringing Medicare and Medicaid programs for the aged and poor into existence. The second effort, the attempt to pass a national health care plan to ensure coverage of all Americans in the early 1990s by President Clinton, ended in failure. This dissertation focuses on the processes of policy formulation and adoption associated with each period in an effort to illuminate the critical elements and processes necessary for successful policy change. The result of this analysis is to inform progressives, including social workers and their allies, of a potential way forward to universal health care in the United States in the 21st century.

While Johnson and Clinton share many similarities, the differences are equally noteworthy. Johnson had a veto-proof majority in Congress, and a filibuster-proof majority in the Senate. Clinton's majorities were slimmer. Johnson was elected with a landslide majority of 61 percent of the popular vote, in part due to an expanding economy and his inheritance of the country's trust in the wake of the JFK assassination (Goodwin,

1991; L. B. Johnson, 1971; Lyndon Baines Johnson Library and Museum, 2006). Johnson inherited a populace who had experienced government efficacy in the form of New Deal and Social Security programs, as well as relatively recent victory in World War II, defeating fascism. Cold War geopolitics, brought to a fear-inducing fever pitch by the Cuban missile crisis, contributed to Johnson's 1964 victory as Republican nominee Barry Goldwater went far right on communism and Johnson answered Goldwater's tactics by showing his own resolve against communism in the wake of the Gulf of Tonkin (Grubin, 1991; L. B. Johnson, 1971).

Clinton inherited an economy in deep recession, a country in the midst of a startling electoral realignment, and a populace with diminished faith in government's effectiveness, in part due to previous presidential administrations' failures (H. Johnson & Broder, 1997; D. Morris & McGann, 2004). The Watergate scandals of Richard Milhous Nixon had severely eroded public faith in the presidency. The public lost faith in the efficacy of government as the economy faltered under Gerald Ford and Jimmy Carter. The Reagan Revolution had led to deep division in the country as Ronald Reagan capitalized on the culture wars to bring the Republican Party back to power. Clinton was elected to his first term with only 43 percent of the popular vote, though he enjoyed a wide margin in the Electoral College.

Factors outside the government also differed between the administrations. Organized labor, traditionally a bastion of support for the Democratic Party, was a much stronger force in the 1960s than in the early 1990s. Labor leaders supported both the Johnson health care efforts and the Clinton efforts, but the decline in union membership during and following the Reagan administration meant that unions were considerably less effective in the Clinton case (Hacker, 1997; H. Johnson & Broder, 1997). The media explosion, both in terms of cable television programming and the Internet was a factor

Clinton faced that Johnson did not. This meant that the media had considerably more power to set the political agenda, and was available as a powerful weapon in a political battle. That conservatives and their allies made better use of that weapon in the Clinton health care battle than did progressives and their allies is in itself an important historical and political lesson (H. Johnson & Broder, 1997; Lakoff, 2006; Skocpol, 1996).

Clinton took office in a period influenced by the legacy of the Johnson Administration and the huge government insurance programs (i.e. Medicare and Medicaid) along with their rapidly escalating costs that had been in place for almost 30 years. He also inherited the countervailing legacy of the Reagan and George H. W. Bush administrations, both of which successfully engineered retractions in the growth of federal social welfare programs.

What difference does the Clinton failure make now? Nearly fifteen years have passed since the whimpering death of the Health Security Act of 1994. There have been four presidential elections since that time and eight congressional elections. According to actuaries and economists at the Centers for Medicare and Medicaid Services (CMS), health care spending is projected to continue its rise, from 16.2 percent of the gross domestic product of the country in 2007 to 20.3 percent in 2018, with spending projected to be $2.4 trillion in 2008 and $4.4 trillion by 2018 (Sisko, et al., 2009). Business is straining under the burden of benefit costs. Economic and political forces appear to be poised to make change difficult in the foreseeable future, with the recession leading CMS actuaries to predict that “differences in growth rates between national health spending and GDP are expected to be the greatest in 2008 and 2009” (Sisko, et al., 2009, p. w346). All these reasons, further explored below, make it important to study the policy formulation efforts of the two Democratic administrations.

Today, President Barack Obama–elected on a platform that included a promise of major health care reform–has inherited an economic crisis of a proportion unseen since the 1930s. Over $1 trillion has been authorized in stimulus spending, tax cuts, and bailout funds for the struggling financial sector, with trillions more obligated in the form of guarantees from the Treasury, the Federal Reserve, and the Federal Deposit Insurance Corporation (Bhide, 2009). The public trust in government is being tested, particularly in the wake of the first round of spending on the Troubled Asset Relief Program (TARP) under Bush's Treasury Secretary Henry Paulson. TARP represented a $350 billion outlay that was followed by rounds of executive bonuses of an estimated $18 billion while banks continued to hoard the funds rather than increase lending as intended. Meanwhile, Congress has authorized a $787 billion stimulus package (Meckler, 2009) for which only three of the 219 Republicans on Capitol Hill voted (Hitt & Weisman, 2009), a demonstration of the country's deep partisan and ideological divide that does not bode well for passing health care legislation that has the potential to increase spending. Republicans, who are supposed to be fiscal conservatives and who held majorities in Congress from 1994 to 2006, have followed a strategic initiative based on spending in such a way that later the government will be unable to sustain itself. Hacker and Pierson (2005) call this strategic initiative "Starving the Beast – Later" (p. 103).

During the recent presidential primary campaigns, Barack Obama espoused a plan that appears, at least on its face, to be considerably more complicated than competing ideas (such as single-payer, among others) and involves a partnership among employers, private insurers, beneficiaries, and the government. He named Tom Daschle, former senator from South Dakota, as the Secretary-Designate of the Department of Health and Human Services. Daschle (2008) has put forth his own proposal for dealing with the health-care crisis. It entails opening the Federal Employee Health Benefits Plan (FEHBP)

to the public and establishing a Federal Health Board, similar to the Federal Reserve Board, which would be at least marginally politically independent, to control health care spending. Daschle withdrew his name from nomination in the wake of a scandal over his failure to pay a portion of his income taxes in past years.

The Obama and Daschle plans differ radically from Clinton's failed "managed competition" plan of 1993. If a new reform initiative is to succeed, it will be important to avoid repeating the mistakes of the early 1990s.

This study is based on four orienting questions, the theoretical basis for which are explored in Chapter Two. In the interest of orienting the reader's expectations about what is to come, I offer the orienting questions, without explanation at this point. These questions are:

1) Relying on a modified approach based on Arthur's (1994) path-dependence model:

a) what historical factors, including political, economic, and direct health policy components, set the stage for the respective success and failure of the Johnson and Clinton health care policy initiatives,

b) were those factors natural, accidental, or planned, and

c) in what sequence did they occur to facilitate the respective outcomes?

2) To what extent did the two presidents, their staffs, and legislators of the two time periods act to foment or facilitate these factors, and, in the absence of any such direct action, in what ways did they react to or utilize these factors in pushing for passage of the respective presidential health care policy initiatives?

3) What were the barriers to legislative passage, and what steps, if any, did members of the respective administrations, legislators, and policy activists such as social workers take – or should they have reasonably taken – to overcome these barriers?

4) To the extent that conditions have changed since the 1990s, what can social workers and allied policy activist groups do to:

a) hasten the process of health care reform by reducing political barriers;

b) recognize opportunities to advance reform initiatives;

c) prepare for swift action when the path to new policy change options opens; and

d) utilize strengths of the social work profession (e.g., case management, clinical skills, advocacy skills) to ease the transition to national health care if and when that time arises?

A WORD ABOUT THE REMAINING CHAPTERS

Chapter Two: "American Health Care at the Breaking Point" opens with a brief cultural and historical examination setting the stage for a consideration of the current state of health care and health-care related policy in the United States. This chapter discusses the importance of this study and provides a statement of the problems confronting any new effort at reforming health care in the United States. It also includes a brief review of the major literature surrounding the topic. The literature is further explored in subsequent chapters as a way of verifying findings from the source documents used in this study as well as filling gaps in the presidential records.

Chapter Three: "The Path-Dependent Nature of Federal Health Policy" addresses the theoretical framework for the ensuing comparative policy development analysis of the two administrations. The chapter includes the methodology that I used in developing the comparative policy development analysis, as well as the orienting questions that have

driven the research and subsequent analysis. Additionally, this chapter describes the data sources that were examined to answer the orienting questions.

Chapter Four: "The Road to Medicare and Medicaid" further explores the history of federal health policy from the Progressive Era to Lyndon Baines Johnson's ascent to the oval office. It examines the sequence and timing of relevant events prior to his presidency. This chapter defines the early decisions that shaped the cultural and structural state of the health care delivery system prior to Medicaid's enactment.

Chapter Five: "For Such a Time as This" is a case study of Lyndon Baines Johnson's presidential administration, the legislative tempo of that era, and the factors that converged to open the path to a massive shift in federal health policy. It includes an exploration of Johnson's reaction to the opportunity, the political barriers faced in the reform effort, and the methods, tools, and techniques Johnson and his administration utilized to overcome those barriers.

Chapter Six: "The Interim" looks at the period following enactment and implementation of Medicare and Medicaid from the mid-1960s to Bill Clinton's election in 1992. It examines the path of federal health policy and the parallel paths of medical inflation and the American labor movement as well as the effects of Medicare and Medicaid implementation on the political environment prior to Clinton's assumption of the presidency.

Chapter Seven: "Too Much Money, Too Little Time," is a case study of William Jefferson Clinton's presidential administration, his Task Force on National Health Reform, and the legislative and institutional conditions that halted his health care initiative. In this chapter, I examine the available evidence as to the Clinton team's assessment and understanding of the options available to them for reform, as well as

activities undertaken by the Clinton administration and its constituencies that may have influenced the outcome of the initiative.

Chapter Eight: "Lessons Learned" attempts to draw comparisons between the two presidents and their administrations as they each sought to create a massive shift in federal health policy. In this chapter, I attempt to consolidate the answers from the first three orienting questions into a cohesive and comprehensive path-dependence analysis of the two periods, leading to the final chapter's exploration of the future.

Chapter Nine: "The Road to Somewhere" focuses on the future of national health care in the United States given the paths that policy, the medical-industrial complex, and labor conditions have taken to date. The chapter opens with an analysis of post-1994 implications for federal health care policy. I then attempt to apply the lessons learned to both current conditions and predictions about the path ahead. This chapter focuses on answering the last of the orienting questions, stated briefly as: How do policy allies, including social workers, prepare for, recognize, and facilitate future health policy reforms in the quest for social justice and access for all?

CONCLUSION

As the political system of the United States heats up again towards reform of its health care delivery and payment system, it is important to determine what Americans must be able to expect from their leaders. Presidents Johnson and Clinton provide contrasting case studies in almost every way imaginable—contrasting leadership styles, contrasting political experience, and, without question, contrasting policy outcomes. To date, there has been no comprehensive comparison of these two contrasting examples. If the United States is ever to achieve universal health care, it will be helpful for President Obama or some future president to understand the processes which have historically led to a successful policy outcome. While there may be many paths to achieve a successful

policy change, avoiding historical mistakes should help move the policy forward more quickly. That is the purpose of this dissertation.

Chapter 2:
American Health Care at the Breaking Point

CULTURAL AND STRUCTURAL DIMENSIONS LEADING TO THE STATUS QUO

The United States is the only developed nation that does not have a comprehensive national approach to health care delivery. Rather, our system is fractured into a complicated web of government and private-sector types of insurance-based coverage that creates a veritable "Turkish bazaar" of health care. On the government side, there is Medicare, Medicaid, the State Children's Health Insurance Program, military hospitals (for active duty personnel), and the Veterans' Administration hospitals and clinics (for military veterans). On the private side, large employers often utilize self-insured plans, the next largest employers typically enroll employees in experience-rated group health insurance policies, and the self-employed typically choose either association plans—for example, group plans available for members of a business association or credit union—or individual plans. Meanwhile, roughly 46 million people are uninsured and rely on emergency rooms, free or low-cost community clinics, or urgent-care clinics as their primary point of contact with the health care system (Kaiser Commission on Medicaid and the Uninsured, 2006, 2007; Kaiser Family Foundation, 2009b). Many of the uninsured are employed by small businesses whose owners deem it unaffordable to offer their employees health insurance.

HEALTH CARE TODAY

According to the United States Census Bureau, 45.7 million people were uninsured in 2007, a decrease in the number of uninsured of 1.3 million from 2006. This decline represented a 0.5 percent drop in the uninsured rate from 15.8 percent to 15.3 percent (DeNavas-Walt, Proctor, & Smith, 2008). As Figure 2 below illustrates, the

number of people uninsured increased steadily from about 31 million in 1987 to 47 million in 2006, while the rate increased from about 13 percent in 1987 to 15.8 percent in 2006. Whether the change in direction from 2006 to 2007 represents a new trend remains to be seen. A change in the way the questions were asked and the statistics were calculated in 2000 (for which 1999 data was collected) resulted in an increase in the number and percentage of persons insured.[1] The Census Bureau has not explicated the extent of the increase resulting from these changes in data collection. However, one can draw a reliable inference that the number and rate reported uninsured would be greater had the changes in data collection not occurred. The increase in percentage insured is due to an increase in the number covered by *government* plans (Medicare, Medicaid, military health care, Veterans' Administration hospitals and clinics, and the State Children's Health Insurance Program [SCHIP]). The percentage of people covered by private insurance and the percentage covered by employment-based insurance both *declined* by 0.4% each. The number covered by government health insurance increased by 1.7 million from 80.3 million in 2006 to 83 million in 2007, a larger number than the total decrease in uninsured over the same period. This represents an increase in the percentage of population covered by government programs of 0.8 percent from 27 percent in 2006 to 27.8 percent in 2007 (DeNavas-Walt, et al., 2008).

This same report points out that the number of children under 18 years of age without health insurance decreased from 8.7 million in 2006 to 8.1 million in 2007, a number still higher than the 8 million in 2005. This represented a decrease in the rate of uninsured children from 11.7 percent in 2006 to 11 percent in 2007, up slightly from the

[1] The sample for the 2000 Annual Social and Economic Supplement (ASEC), which asked about the year 1999, was based on the 2000 Decennial Census data. Additionally, beginning with the 2000 Current Population Survey (of which ASEC is a part), those respondents who answered "no" to each question by coverage type are then asked to verify whether they were, in fact, not covered by any type of health insurance. Whether this results in more accurate reporting has not been determined as far as I know. I offer the footnote only to partially explain the "glitch" in Figure 1.

10.9 percent in 2005. Children in poverty had an uninsured rate of 17.6 percent in 2007, down from 19.3 percent in 2006, though children living in poverty were still "more likely to be uninsured than all children" (DeNavas-Walt, et al., 2008, p. 20).

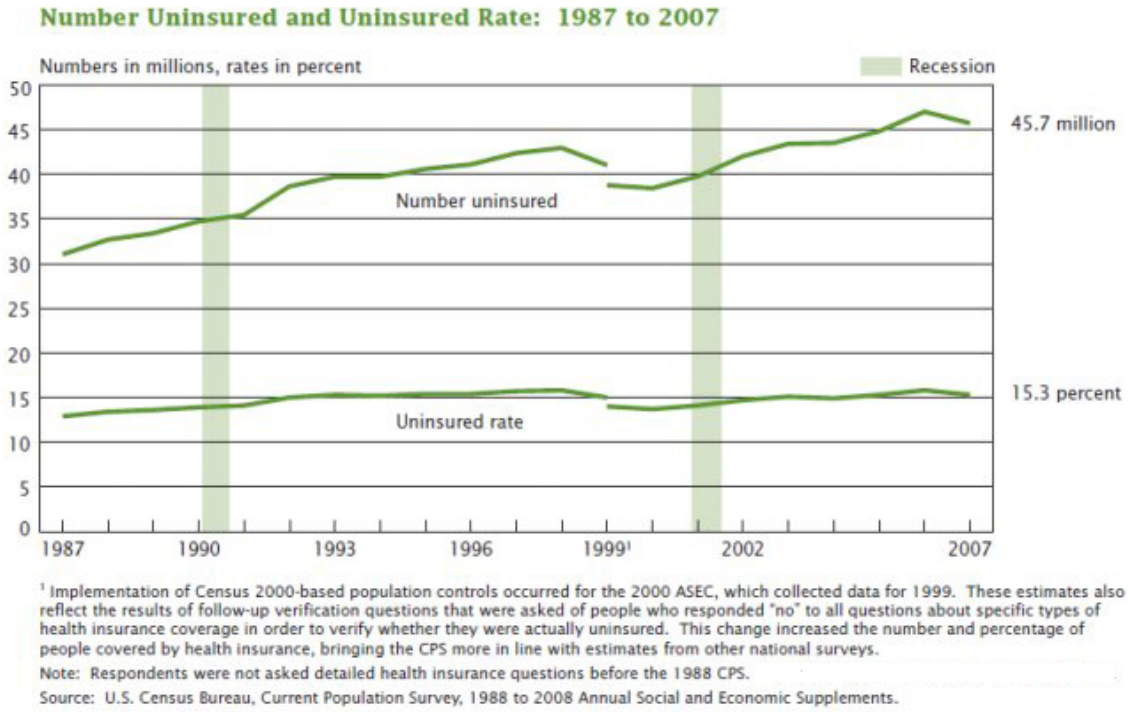


Figure 1: Number Uninsured and Uninsured Rate: 1987 to 2007 (DeNavas-Walt, Proctor, & Smith, 2008)

Comparing these rates to historical data, the number of uninsured children in the United States was 8.1 million in 1987. That number reached 9.5 million in 1993 and peaked at around 10.7 million in 1998. The numbers then began to steadily decline to around 7.8 million in 2004, then slowly climbed until 2007 when they declined again. The decline in numbers is likely attributable to the passage of the State Child Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997. However, in 1987, 40.4 percent of uninsured children were living in families below the federal poverty line. By 1993, this had changed to 33.5 percent of uninsured children. In 2005, of

the 8.1 million uninsured children, 30.1 percent lived below the federal poverty line (U.S. Census Bureau, 2006).

Uninsured rates for non-Hispanic Whites decreased from 10.8 percent in 2006 to 10.4 percent in 2007, with a decrease in numbers from 21.2 million uninsured in 2006 to 20.5 million in 2007. The number of uninsured African-Americans also decreased from 7.6 million in 2006 to 7.4 million in 2007, still higher than the 7.1 million in 2005 (decrease in rate from 20.5 percent to 19.5 percent), while the percentage of uninsured Hispanics decreased to 32.1 percent, representing 14.8 million people in 2007 (DeNavas-Walt, Proctor, & Smith, 2007; 2008).

Economic status is a predictor of insured status. Only 75.5 percent of people living in households with incomes less than $25,000 in 2007 were insured. Coverage rates increased to 92.2 percent of people living in households with incomes of $75,000 or more. This indicates that cost of coverage, as well as full-time employment status, significantly impacts the likelihood of being covered (DeNavas-Walt, et al., 2008).

In 1995, the Census Bureau (Bennefield, 1995) reported that "Despite the existence of programs such as Medicaid and Medicare, 29.1 percent of the poor (11.1 million) had no health insurance of any kind during 1994. This percentage [of uninsured poor] was about double the rate for all persons. Poor persons comprised 27.8 percent of all uninsured persons" (p. 1). The same report indicated that young adults aged 18-24 were the most likely to be without coverage during all of 1994; persons of Hispanic origin were almost 3 times as likely as Whites to be without coverage; and part-time workers had the highest non-coverage rate at 19.5 percent. Notably, non-workers had the lowest uninsured rate at 13.4 percent, which was attributed to Medicare coverage of the elderly and the Medicaid program (though it should be noted that many doctors refuse to accept Medicaid and some, if not many, are not accepting any new Medicare patients).

The report also noted that “Among the poor, workers had a far higher uninsured rate than nonworkers [sic]” (p. 1). In 2006, 31.6 percent of people living under the poverty line had no coverage at any time during the year, and those living under the federal poverty line comprised 24.6 percent (11.5 million) of all uninsured persons. The bar charts in Appendix B illustrate the percentage uninsured during 2007 by race, age, household income, and working status (U.S. Census Bureau, 2007a, 2007b).

Poverty continues to be a predictor of increased risk for being in a non-covered status. It is reasonable to expect that the number of uninsured might actually decrease in 2008 as it did in 2007 as more people are added to the government health insurance rolls. This would be a natural consequence of the dramatic increase in unemployment in the last quarter of 2008 resulting in working poor—or at least their dependent children—who were not covered becoming eligible for Medicaid and/or SCHIP coverage due to the loss of income. We already know that higher income households are far more likely to be covered than the working poor. In this light, it is appropriate to consider income dispersion among United States households.

POVERTY AND PLENTY

Over the 2006-2007 reporting period, the Census Bureau reported an increase in the number of people living in poverty from 36.5 million in 2006 to 37.3 million in 2007. The poverty rate also increased from 12.3 percent in 2006 to 12.5 percent in 2007. Over this same period, real median household income rose for the third consecutive year from $49,568 to $50,233, an increase of 1.3 percent. Notably, the number and percent of insured persons rose during that same period (DeNavas-Walt, et al., 2008).

Inequality in income is traditionally measured using two methods: the shares of aggregate income by households, normally divided into quintiles, and the Gini index. The Census Bureau reported that “the changes in the shares of aggregate household income

received by quintiles indicated a decrease in income inequality between 2006 and 2007" (DeNavas-Walt, et al., 2008, p. 8). While this may sound like good news on first blush, it is important to remember that the bottom quintile receives 3.4 percent of the nation's total income (down from a high of 4.4 percent in the mid-1970s), while the top quintile receives 49.7 percent of the nation's total income (up from a low of 42.8 percent in 1968). Eighty percent of American households share just over half of the income in the United States. Meanwhile, the top 5 percent of households rose from a low share of 15.6 percent in 1981 to 21.2 percent of total aggregate income in 2006 (DeNavas-Walt, et al., 2008; U.S. Census Bureau, 2007c),

The Gini index, a ratio that expresses the inequality of distribution of a variable, captures income dispersion across the entire income distribution in a single measure. The index ranges from 0, which would indicate perfect equality (everyone receives an equal share of income) to 1 representing perfect inequality (all income received by one recipient). An increase in the Gini index for income indicates greater inequality in income distribution—a widening of the gap between the poor and the rich. The Gini index allows for comparison of inequality regardless of changes in the size of the population or of the economy. For 2007, the Gini index was 0.463, compared to a 2006 Gini index of 0.470 a decrease in inequality of 1.5 percent, notable, but still "not statistically different from any of the annual Gini indexes [sic] over the 1997 to 2005 period" (DeNavas-Walt, et al., 2008, p. 9).

I examined the annual Gini index from 1987 to 2007 and compared it to the annual reported percentage of the population that was uninsured for the same period (data for both variables was available only over this 21 year period). The Gini index ranged from .236 to .470 over the period. The percentage uninsured ranged from 12.9% to 16.3% (DeNavas-Walt, et al., 2008). Using SPSS (SPSS Inc., 2002), I performed a linear

regression analysis (N=21) using the percentage uninsured as the dependent variable and the Gini index as the independent variable. Results showed that the two were moderately correlated ($p<.001$) with an R-squared of .484 indicating the variance in the Gini index accounted for 48.4% of the variance in the percentage uninsured.

Data from the previous section indicated that the chances of being uninsured in the United States are significantly greater among the nation's poor. Further, trends in the growth of the rate of uninsured mirror trends in income distribution. It indicates that race and economic status play a role in predicting insured status. Most importantly, it shows that overall, since the last serious attempt to strengthen health care access in the United States, rates of health care coverage have decreased, not increased.

PRICING OF HOSPITAL CARE

In his 2007 study funded by the Kaiser Family Foundation, Anderson (2007; also see DeNavas-Walt, et al., 2008) found that the "rates charged to many uninsured and other 'self-pay' patients for hospital charges were often 2.5 times what most health insurers actually paid and more than three times the hospital's Medicare-allowable costs" (p. 780). Anderson further noted that this gap had increased considerably since the mid-1980s. This makes it extremely difficult for many self-pay (uninsured) patients to pay their hospital bills. Anderson did not address other medical costs, such as doctor's bills, durable medical equipment, home health care, or nursing care.

Anderson (2007) further notes the dramatic change this represents in cost-shifting dynamics post-Medicare. In fact, according to Kessel (1958), it was most common in the medical profession in the early twentieth century to charge according to a sliding scale, much like the progressive income tax.

Anderson (2007) found that hospital charges as a factor of hospital costs rose from a charge-to-cost ratio (total charges divided by total costs) of 1.35 in 1984 to 3.07 in

2004, with hospital charges per admission rising 10.7 percent on average over the same period. However, over this same twenty-year period, Medicare-allowable costs rose only 6.3 percent, very close to the increase in net hospital revenue of 6.6 percent per year.

Anderson (2007) then turned his attention to the justifications given by hospitals for these widely-discriminatory pricing plans. He outlines, and debunks, six common justifications: (1) patient responsibility to negotiate a discount in advance, (2) charity-care policies, (3) solvency, (4) negotiating strategy with managed care plans, (5) Medicare outlier payments, and (6) geographic competitors. Each warrants a brief explanation.

Patient responsibility as a justification refers to hospitals' argument that the patient is responsible to negotiate a discount *prior* to service being rendered. Anderson (2007) notes that patients must know to ask in advance, be approved by the hospital, and, even if all of that occurs, the discount is much less than what insurers receive. I might add that it is also relatively difficult, if not outright impossible, for the patient to negotiate price in the face of a medical emergency.

Most hospitals provide some charity care, but Anderson (2007) notes that even with their inflated charges, many hospitals still have difficulty meeting the requirements of various state laws for the amount of free care they must offer. Meanwhile, even though hospitals collect only 10% of charges on average from uninsured patients, many of them pursue aggressive collection strategies resulting in an increased role of medical care costs in personal bankruptcy filings. Even including the insured, as late as 2001, as many as half of bankruptcy filers surveyed cited medical expenses as the primary cause of their bankruptcy (Himmelstein, Warren, Thorne, & Woolhandler, 2005).

Some hospitals point to solvency as a rationale for these discriminatory charging policies. Noting that Medicare, Medicaid and negotiated contracts with managed care

plans have squeezed profit margins, these hospitals justify cost-shifting to the uninsured to make up for lost profits. Anderson (2007) notes two problems with this justification. First, hospitals' desire to earn a profit does not justify charging uninsured and self-pay patients more than double what hospitals charge public and private insurers. Second, there is virtually no difference to hospitals in the costs of medical care for patients by insured status.

Negotiating strategy with managed care plans represents the fourth justification. In this model, hospitals maintain that charging high rates for non-contracted managed care plans raises the incentives for managed care plans to contract with the hospital (Anderson, 2007).

In the past, a drive to obtain higher outlier payments from Medicare caused some hospitals to increase charges. Outlier payments are payments outside the normal range for a geographic area based upon the hospital's own actual charges to non-Medicare patients. This strategy, along with the negotiation strategy outlined above, take no notice of the fact that uninsured and self-pay patients are expected to pay these higher prices, resulting in increased collection attempts and defaults for these higher charges (Anderson, 2007).

Finally, hospitals argue that other hospitals in their same geographic area charge substantially similar rates. Anderson (2007) notes that chargemaster files, the master list of hospital charges usually comprising some 25,000 items and services, are confidential and typically not available to the public. This makes it impossible for patients to comparison shop for hospital services.

It would be tempting to argue that hospitals could increase their base of business by charging less, on the theory that customers will not pay more for the same service unless they perceive the lower-priced service to be inferior, i.e., price is a marker of quality to the consumer. This argument applies in a market where there is equality, or at

least near-equality, of information on the part of buyer and seller. This, of course, is not the case with hospital pricing. Furthermore, such an argument presumes that people *could* at least shop for a cheaper hospital. Practically speaking, however, many locales do not have multiple hospitals from which to choose. Also, in areas that do have multiple hospitals, the patient's physician may only practice at one hospital, which would dictate the patient's "choice" of hospital. Finally, in cities where there are multiple hospitals, many services have been divided between the competitors, especially such higher-priced services such as Magnetic Resonance Imaging, lithotripsy and lasertripsy for kidney stones, and cardiac specialty care among others. In many cases, these facilities must obtain a Certificate of Need from the state in order to purchase high-cost equipment. These certificates are typically not offered to multiple hospitals in the same geographic area (except for very densely populated large cities). These factors combine (dare one say "conspire") to prevent patient choice based upon price. If I am correct in these assertions, then pricing is no longer based strictly upon consumer demand. The demand curve would be relatively flat—that is, the demand does not fluctuate (or fluctuates very little) by price. This applies mostly to the uninsured, those paying the so-called "rack rate" prices. Large buyers such as insurance companies, managed care organizations, or large self-insured employers, can and certainly do negotiate a lower price. Individuals, as the system is currently configured, have little real negotiating power and even less knowledge of the pricing structures. If this were to change, then Herzlinger's (2007) consumer-driven approach might stand a fighting chance.

Whatever the rationales for what hospitals charge, especially what they charge the uninsured, the results are devastating. Anderson (2007) notes that what it costs hospitals to care for the uninsured on a procedure-for-procedure basis is very close to that of insured patients with the bulk of any increase attributable to extra billing and

collections costs. The effects for the patient and his or her family, however, are often devastating.

Anderson (2007) offers two options for reducing rates for self-pay patients: price transparency and maximum-rate setting. Price transparency was a priority of the Bush Administration, and pending legislation has caused some hospitals to begin publishing price data on the Internet. However, these are largely published at the diagnosis-related group (DRG) level and not at the price level in the chargemaster file, the price basis for charges to self-pay patients. DRGs began to play a role in Medicare financing in 1984, as a way of paying *prospectively* for services based on what costs could be expected based on a patient's diagnosis. This is how Medicare pays for hospital charges (Marmor, 2000). Self-pay patients, however, do not pay based on DRG charges prospectively. Rather, they pay for each service and each item according to the master list, known as the chargemaster. This calls the value of the published data into question.

Setting maximum rates is the second solution Anderson (2007) proposes. He further breaks this into three categories of action: (1) voluntary rate setting by hospitals, (2) litigation, and (3) legislation. In the first of these categories, voluntary action by hospitals, Anderson notes that the American Hospital Association (AHA) has recently published voluntary guidelines which would have uninsured patients with income below 100 percent of the federal poverty line (FPL) paying nothing, those between 100-200 percent of FPL paying no more than the price paid by a public or private insurer contracting with the hospital or 125 percent of the Medicare rate, and patients above 200 percent of FPL priced at the hospital's discretion. It is unclear whether these very recently published non-binding principles will be adopted.

Litigation on the basis of discriminatory pricing, the second action category, has already begun to spring up in numerous class action suits around the country. Getting the

uninsured certified as a class has posed difficulties, but once class certification is attained, the defendant hospitals typically settle the case. These settlements have typically given discounts to the uninsured at FPL levels *higher* than those recommended by the AHA guidelines (G. F. Anderson, 2007).

Finally, Anderson (2007) offers the legislative remedy, in which legislation would mandate price regulation if hospitals do not adopt the voluntary AHA guidelines or court proceedings grow onerous. He notes that the effects of rate reductions from whatever source, while unknown, would likely result in greater collections and fewer personal bankruptcies. Since most hospitals do not expect the uninsured to actually pay the charges, Anderson discounts any effect on access to hospital care. However, this neglects the fact that uninsured persons may be more likely to receive care if they do not feel that it will put them in dire financial jeopardy. He also fails to address similar practices by physicians and other health providers that would, in the face of such reductions in pricing disparity, increase the likelihood that the uninsured would acquire health care *before* requiring hospitalization, which would further reduce the overall costs of hospitalization in the national health expenditures as well as to the individual patient.

TRENDS IN EMPLOYMENT-BASED INSURANCE

Employment based insurance has been the backbone of the health care financing system in the United States since World War II. In October, 1942, Congress enacted the Stabilization Act 56 Stat. 765, limiting wage increases by employers as part of an effort to control inflation during World War II. Though most Stabilization Act provisions had been lifted by 1946 (Campbell, 1949), the relatively brief period of wage and price controls had some lasting effects regarding the nexus between employment and health insurance. While it limited wage increases, the Act did permit the adoption of employee insurance plans. As a result, business and labor agreed to replace wage increases with

fringe benefits, including employer-provided health insurance. This nexus between employment and insurance was further reinforced by rulings of the IRS that gave such employer-provided benefits favorable tax treatment in that they were deductible to the employer while being non-reportable as income to the employee. Collective bargaining agreements began to include medical insurance on a widespread basis. From 1940 to 1950, the percentage of insured in the United States population jumped from about 9 percent to roughly 50 percent. In the 1950s, vision and dental benefits emerged for the first time. Health Maintenance Organizations (HMOs) had been around since at least 1929, with the largest HMO, Kaiser Permanente, founded in the 1930s (Scofea, 1994a). By the 1970s, with costs rising almost exponentially, managed care—in the primary forms of HMOs and Preferred Provider Organizations (PPOs)—began to receive government attention. In 1973, Congress passed the Health Maintenance Organization Act under the Nixon Administration in an effort to encourage formation of additional comprehensive prepaid medical care programs (Scofea, 1994b; Weathers, 2004).

According to Acs and Sabelhaus (1995), between 1980 and 1990, the share of increased medical spending borne by employers, governments, and households rose proportionately to the baseline percentage of spending that each sector represented in 1980. However, from 1990-92, government's share increased while household out-of-pocket spending declined (Acs & Sabelhaus, 1995). This suggests that spending increases are hidden in costs of other non-health goods purchased and in increases in government debt. According to the Centers for Medicare and Medicaid Services (CMS), out-of-pocket payments peaked in 1993 at 18.9 percent of total health care spending, declining to 15.9 percent of total health care spending by 2002 (Buckley & Van Giezen, 2004). In 2007, out-of-pocket spending grew 5.3 percent, up from 3.3 percent in 2006. CMS attributed the acceleration to increased out-of-pocket payments for prescription drugs,

nursing home services, and nondurable medical supplies (CMS Office of Public Affairs, 2009).

Employer-provided insurance has changed over the past fifty years. Initially paying on an indemnity basis (e.g., $35 per day for hospital expense) in the 1960s, the trend moved toward more comprehensive major medical coverage in the 1970s and 1980s. In the early 1990s, employers began shifting more costs to employees in the form of premium-sharing for both employee and family coverage, and in the form of higher deductibles and out-of-pocket maximums (Scofea, 1994a). The percentage of costs paid out-of-pocket has declined, but this is more likely a factor of the comprehensive nature of the coverage (more services are covered) and reflects the fact that health care spending tends to concentrate in the top 20 percent of users when ranked by total annual spending per person. According to Kaiser Family Foundation (Kaiser Family Foundation, 2009a) calculations, 79.8 percent of health care expenditures in 2006 were spent on the top 20 percent of medical care consumers (those with health care spending in excess of $4,028 for the year). According to the same report, in 2006, the top 1 percent (those with health care spending in excess of $41,579 for the year) consumed 21.2 percent of all health care spending. From this, one can conclude that while the *percentage* of total spending paid out-of-pocket has declined, the total *amount* the consumer expends has increased, with first-dollar benefits (those paid prior to insurance picking up any costs) actually rising over the period.

From the inception of the Blue Cross and Blue Shield plans, health insurance in the United States has been structured around a *treatment* model rather than a *preventive* medicine model. This could be viewed as a reflection of the moral hazard archetype that is prevalent in the American collective psyche. Moral hazard exists to the extent that the cost of a benefit to an individual exceeds its value as a societal benefit (Auger &

Goldberg, 1974; Donaldson & Gerard, 1989; Ma & Riordan, 2002; Nyman, 2007). In the case of health insurance, the fear is that people will overuse the system unless they have some economic interest which restrains them from doing so. This plays out in the form of deductibles, co-payments, and co-insurance. The theory cum ideology behind this is that first-dollar expenses are the most expensive to cover and that raising deductibles, co-pays, and co-insurance amounts is the best way to constrain use of the system and therefore constrain costs (Auger & Goldberg, 1974; Ma & Riordan, 2002). As the United States spends more per capita on health care than any other developed nation without achieving anywhere near the best health outcomes by any current measure of outcomes, the evidence surrounding this ideology is mixed at best (Donaldson & Gerard, 1989; Nyman, 2007). Compounding this is the evidence that shows that 21.2 percent of health care expenditures in the United States are paid for the top 1 percent of the population ranked by health care spending, comprising persons with average claims greater than or equal to $41,580. Fully 47.7 percent of claims are paid out for the top 5 percent, with average annual expenditure per person in excess of $14,600. By comparison, those spending less than $776 per year (the bottom 50 percent) account for only 3.2 percent of spending (Kaiser Family Foundation, 2009a). Clearly, the bulk of expenditures in the United States is going to large claims, a reflection of the treatment versus prevention model that we have come to espouse.

This points to a conundrum. Some analysts attribute at least part of the rise in total national health expenditures (combined public and private expenditures) to a rising demand as out-of-pocket expenses have declined (Scofea, 1994a; U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services, 2007). However, it should be noted that first-dollar costs (deductibles and co-pays) have not declined. Instead, the rise in these costs to individuals has likely contributed to the

concentration of expenditures into high-cost spending-per-person categories noted above as consumers put off routine and preventive care. This results in increased treatment costs as chronic conditions go untreated until they become acute problems. Common approaches that employers have utilized to reduce their costs include high-deductible plans, bare-bones coverage, catastrophic care plans, preventive-care plans, and recent state-based government plans for small businesses. All of these, with the possible exception of the state-based plans, shift more of the cost burden onto the employee (Hawthorne, 2007). Furthermore, as these first-dollar cost shifts increase employee cost of accessing preventative care, illnesses and injuries are presumably more likely to be medically ignored until such time as they can no longer be ignored, ultimately resulting in a higher cost of treatment than might have been the case had earlier treatment been sought.

The culture of health care took a bit of a turn in the 1970s when Richard Milhous Nixon became convinced (largely by Edgar Kaiser's intervention) that managed care was the answer to reducing health care costs. Whether managed care has slowed the growth of costs is an ongoing debate beyond the scope of this project. It would be exceedingly difficult, however, to make a legitimate argument that managed care held down costs, when one considers that per capita spending has gone from $366 in 1970 to $7,421 in 2007 (Centers for Medicare & Medicaid Services, 2009). Adjusting for inflation, $366 in 1970 is the equivalent of $1,934 in 2007 dollars. In other words, per capita spending increased over the period at 3.8 times the rate of the consumer price index. Nevertheless, the managed care concept has become an ingrained structural component of the culture surrounding how we pay for health care in the United States; so ingrained that it was a major focus of Clinton's approach called "managed competition."

As I explore further in this chapter, the cultural and structural environment is couched in the terms of free market economics, though it is difficult to reconcile the idea of a market-driven system given that 45.3 percent of personal health care expenditures come from public sources (Kaiser Family Foundation, 2009b), and that a significant portion of the remaining 54.7 percent is paid for with public funds in the form of tax subsidies (Daschle, 2008; Kotlikoff, 2007). It is this culture-bound free market ideology that informs proposals to reduce health care costs such as Kotlikoff's (2007) proposal favoring universal health insurance (funded through existing for-profit insurance companies)[2] and Herzlinger's (2007) ideas on consumer-driven health care.[3]

HOW NATIONAL HEALTH EXPENDITURES RELATE TO THE AMERICAN ECONOMY

National health expenditures as both a percentage of gross domestic product (GDP) and on a per capita basis have grown at an alarming rate since 1960. In 1960, national health expenditures were just 5.2 percent of the GDP and per capita spending was just $148 per person in the United States. Between 1980 and 1990, the share of GDP rose from 9.1 percent to 12.3 percent while the per capita spending increased from $1,102 to $2,813. Over the following five years, from 1990 to 1995, the share of GDP rose to 13.7 percent and the per capital expenditure rose from $2,813 to $3,783. The share of

[2] Kotlikoff proposes a single-payer to pay the *premiums* for health insurance to the existing for-profit health insurance companies. His plan suffers from economic reductionism, failing to take into account basic insurance principles such as adverse selection which would counter his proposal. It presumes that companies would willingly go along with the requirements of the plan, a presumption that is far from guaranteed. For a more complete explanation of this author's critique of the Kotlikoff plan, see: Johnson, D. H. (2008). Book review of Laurence J. Kotlikoff's The health care fix: Universal insurance for all Americans. *Michigan Journal of Public Affairs (5)*, pp. 1-6.

[3] The current sub-prime lending crisis, which has its roots in predatory lending, illustrates the flaws in consumer-driven health care models such as Regina Herzlinger's. Many, if not most, consumers are vulnerable due to a lack of education specifically about how they might negotiate with a complex financing system. In the case of mortgages, this was the banking and mortgage brokerage system. In the case of health care, this complex system is the negotiated (and quite secret) pricing structure that providers, especially hospitals, employ. Add to this the information imbalance between provider (physician) and consumer (patient), and there is little case to be made for a rational choice model to reduce health care expenditures under the current system.

GDP remained relatively constant fluctuating only between 13.6 percent and 13.8 percent between 1995 and 2000, while per capita spending rose steadily over the period from $3,783 per person to $4,790 per person over the period (Kaiser Commission on Medicaid and the Uninsured, 2007; U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services, 2007).

However, these figures began a dramatic climb in 2001, with share of GDP jumping from 13.8 percent the previous year to 14.5 percent and continuing to climb to a 2005 level of 16.0 percent of GDP. Per capita spending rose from $5,148 to $6,697 over the same period. In 2005, total national health expenditures in the United States were just short of $2 trillion (Kaiser Commission on Medicaid and the Uninsured, 2007; U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services, 2007), up from just under $1.5 trillion in 2001 (Cowan, Catlin, Smith, & Sensening, 2004).

Medicare and Medicaid themselves almost certainly contributed to the rapid rise in medical costs in the wake of implementation. Initially, costs likely increased as providers had eleven months between signing of the bill (July 31, 1965) and its implementation (July 1, 1966) to adjust their charges upward in view of the "usual, customary, and reasonable charge" provisions of the Social Security Amendments of 1965. These provisions set the limits for provider payments to what was usual, customary, and reasonable for the same or similar services in the same geographic area. This had the unintended consequence of driving costs higher. Additionally, as more elderly and poor people had access to care which was largely (though not completely) paid for by government funds, demand for medical services increased which also raised prices.

Where are expenditures going from here? No one can be certain, of course, as predictive models are limited. However, the National Health Expenditure forecast projects that by 2016, just seven years from the date of this dissertation, total national health expenditures will nearly double to just over $4,136,000,000,000 and per capita spending is projected to grow to $11,957 (U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services, 2007).

Private insurance plans (including employer-sponsored plans) currently cover just under 36 percent of total national health expenditures. This is projected to rise only slightly to 37 percent by 2016. Public plans (including Medicare and Medicaid) currently pay 45.4 percent of national health expenditures and this figure is projected to rise to 48.7 percent by 2016. This means that public plans alone will pay out just over $2 trillion in 2016, almost exactly what total U.S. health care expenditures were in 2005 (U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services, 2007). According to the Kaiser Family Foundation, the Centers for Medicare and Medicaid Services project that by the year 2016, health spending will rise from its 2005 level of 16.0 percent of GDP (a little less than one-sixth of the economy) to 19.6 percent of GDP, or nearly one-fifth of the total United States economy (Kaiser Commission on Medicaid and the Uninsured, 2007). All of this lends strong credence to President Clinton's observation that we cannot solve the long-term economic problems of the United States without addressing the rising costs of health care in America (H. R. Clinton, 2003; H. Johnson & Broder, 1997).

From this, one might reasonably question whether the problem is that so many Americans do not have health insurance or that the cost of health care is so high. This proposes a false dichotomy in that health care costs themselves can be viewed, at least in part, as a product of non-universal coverage. A full exploration of this relationship is

beyond the scope of this dissertation and better left to the health economists. However, a movement to universal care could facilitate a move to a prevention model of care as opposed to the current treatment model. To the extent that the country can revise its cultural understanding of health care provision along a more preventive model, this should ultimately lower costs or at least shift some of the expenditures from the high-claim per person category to a more equitable distribution of resources. Such equity would like result not from a drive for social justice as much as the actual economics of health care provision.

REVIEW OF THE LITERATURE

Now that I have provided an overview of some of the major issues in health care costs, it would be helpful to set the context in terms of the major contributors to the literature surrounding Presidents Johnson and Clinton and their respective health care reform initiatives. The works of authors on these administrations is further explored throughout the dissertation as I use their work to triangulate my own findings from the archival records and other sources. I mention them here to give some contextual support to the work ahead.

For the purpose of this review, I arrange the literature along thematic lines. I begin with literature of a more biographical nature surrounding the two Presidents and First Lady Hillary Rodham Clinton. This literature has been useful in helping me understand the personalities and how they potentially influenced the policy development and ultimate outcomes. Second, I explore the literature surrounding Medicare *per se* as both policy and program, its development, subsequent changes, and potential impact on post-1965 health policies. Finally, I include an analysis of the major literature surrounding the failed Clinton reform effort and literature either proposing solutions or predicting future reform outcomes.

Presidents Johnson and Clinton and First Lady Hillary Rodham Clinton

Though many people were involved at various steps in the efforts to create or move toward a comprehensive federal health care policy, the three major players from the standpoint of this study are unquestionably Presidents Johnson and Clinton and First Lady Hillary Rodham Clinton. Though some critics might rightly point out that personal memoirs are subject to extreme bias, I find that, allowing for said bias, the memoirs do offer some illumination as to how the actors thought about their roles afterwards, if not into their personalities and how they might have acted in the moment. To this end, I relied upon memoirs of the two Presidents themselves (B. Clinton, 2004; L. B. Johnson, 1971) and First Lady Hillary Rodham Clinton (H. R. Clinton, 2003). A second biography of Johnson that rises almost to the level of autobiography, given the extraordinary direct access granted the author, is the work of Doris Kearns Goodwin (1991), who met President Johnson while working as an administration intern. To a lesser extent, the books by Robert Caro (1982, 1990, 2002) have offered insights more into Lyndon Baines Johnson's pre-presidential life, including his childhood and his years as "Master of the Senate" (Caro, 2002). Some would characterize Goodwin's work as a Johnson apology with some admitted basis for such a characterization. No one would characterize Caro's work as an apology. Caro's bias, if any, seems decidedly different from how the President might have characterized himself, and to this extent provides balance to the perspectives provided by President Johnson directly and through Goodwin. Lawrence O'Brien was another major player in the Johnson administration, having previously served under President Kennedy. O'Brien ran the legislative shop for Johnson during the Medicare efforts (and subsequently served as Johnson's Postmaster General). His memoirs, though not solely devoted to Johnson by any means, provide substantive and

valuable commentary from someone directly involved in the legislative efforts that were the hallmark of the Johnson administrations.

What emerges when examining the literature around President Johnson is a portrait in dualities. There is the commonly-known Johnson—irascible, intimidating, driven by power. These features show up clearly in virtually everything written about the man. The so-called "Johnson treatment"—a style of greeting involving the President towering over and invading the personal space of the other party while placing his hand on the smaller person's shoulder—is the most oft-cited example of this facet of the Johnson personality. What is less publicly-recognized by far is the ingenuity, the subtlety, the finesse, and the political craftsmanship that characterized Lyndon Baines Johnson. One must look deeper than the public caricature to see this side of the President. In my own case, this side first began to reveal itself in some of the oral history interviews in the LBJ Library (Cohen & McComb, 1968; A. E. Goldschmidt & Wickenden, 1969; E. W. Goldschmidt, 1974; Mills, 1971, 1987a, 1987b; Wilson, 1973; Wright, 1974). Larry O'Brien (1985a, 1985b, 1985c, 1985d, 1985e, 1986a, 1986b, 1986c, 1986d, 1986e, 1986f, 1986g, 1986h, 1986i, 1986j, 1986k, 1986l, 1986m, 1987a, 1987b, 1987c, 1987d, 1987e, 1987f, 1987g, 1987h, 1987i, 1987j, 1987k, 1987l, 1987m, 1987n) provided an extensive set of interviews which illuminated the background not only of President Johnson but also of the legislative tone and tempo of the time as well as the Kennedy administration in which Johnson was Vice-President.

Both Bill and Hillary Clinton have published memoirs since their White House years. Each of these has proven helpful in trying to understand their personalities, viewpoints, and operating styles. The husband and wife team of Dick Morris and Eileen McGann (2004) provided a counterpoint reaction to Clinton's memoirs. Morris served for more than two decades as Bill Clinton's close political adviser from his Arkansas

governorship days to the White House. They bill their book as a deconstruction of the Clinton version of the story. The Clinton years are far fresher than the Johnson years in the public's memory. Additional resources not specifically biographical in nature have, nonetheless, provided valuable insights into the Clintons (Hacker, 1997; Hacker & Pierson, 2005; H. Johnson & Broder, 1997; McCaughey, 1994a; Quadagno, 2005; Skocpol, 1996; Starr, 1997).

The Miller Center of Public Affairs at the University of Virginia is conducting an ongoing project to take oral history interviews of key persons associated with the Clinton administration. As of the date of this dissertation, those interviews have not yet been released for scholarly or public use. According to the Miller Center's web site, more than 70 interviews have been conducted, including several with key players in the health care reform effort such as Alice Rivlin and Christopher Jennings. Release of the transcripts is not anticipated until the project is complete "several years hence" (Rector and Visitors of the University of Virginia, 2009). These transcripts will likely provide a richness of detail similar to that found in the extensive oral history collection at the Lyndon Baines Johnson Library and Museum.

Similarly to the duality one finds with Johnson, there is a publicly-known version of Bill Clinton and a less well-known face. The charismatic, political genius who is very good one-on-one or speaking to a crowd is the public face. The lesser known face is one apparently given to bursts of rage when things are not to his liking. The First Lady emerges as somewhat less charismatic than her husband, but perhaps more driven to succeed—a harder worker. She seems to have fashioned herself after Jacqueline Kennedy as a mother but Eleanor Roosevelt as a first lady. Schorr (1997) reported that Mrs. Clinton apparently engaged in an imaginary conversation with Mrs. Roosevelt in a session with a New Age psychologist, a conversation that subsequently was reported in

the media outlets. Shortly after, in Sydney, Australia, she poked fun at herself saying that she had spoken with Eleanor before departing the White House and that "she sends greetings to you all" (Schorr, 1997, p. 6). Hillary Clinton (2003) herself reports the incident though the details vary slightly: she claims that a slightly different quip was made at a conference being hosted by the Gores in Tennessee, though the idea is the same. Her memoir *Living History* includes an entire chapter titled "Conversations with Eleanor."

Literature on Medicare

Almost unquestionably, the author of the seminal work on Medicare and politics is Theodore Marmor (2000), who teaches politics and public policy at Yale University. Marmor's original study was published in 1970. A second edition was published in 2000. Marmor's later edition touches on the Clinton reform attempt, but primarily focuses on how Clinton's Health Security Act addressed Medicare and the extent to which that effort may have influenced subsequent Medicare policy changes, particularly those of 1995 and 1999. Marmor, perhaps displaying a false modesty, claims that his book is not a full history of Medicare. Rather, he sees it as "rang[ing] over the history of Medicare disputes" (p. xx). Marmor's work is organized around three primary issues: 1) why and how Medicare arose as a political issue in both time and form; 2) the responses to various Medicare initiatives; and 3) the outcome or result of this "intense policy struggle" (p. xxi).

If Marmor's (2000) work is the seminal work, it is closely followed by the work of Sheri David (1985), the importance of whose book Marmor freely acknowledges. David, a Special Assistant Professor of History at Hofstra University, takes a more historical approach. As such, the work is primarily chronological in its analysis and relies heavily on both primary source documents as well as interviews with key actors of the

time, notably including Wilbur Cohen, Wilbur Mills, Nelson Cruikshank, and Elizabeth "Wicky" Wickenden. David's acknowledged purpose is not only to provide a rich and detailed historical account of the passage of Medicare and Medicaid, but to examine the choices and options considered as well as the compromises employed in its passage in order to further the understanding of these processes as future health reform debates move forward. Her book primarily focuses on the congressional wrangling that surrounded the passage of the bill.

Marmor's influence has been considerable in terms of the further scholarship surrounding Medicare. For instance, he was the dissertation advisor for Oberlander's (1995) examination of the politics surrounding Medicare between 1965 and 1995. Relying on his interpretation of interviews with policymakers and primary source documents such as records of Congressional hearings and federal reports, Oberlander argued that, contrary to the conventional wisdom, Medicare had represented congressional policymaking largely independent of public opinion or the influence of special interest groups. Specifically, he found that the influence of such groups or of public opinion generally was overstated by the then-current theoretical models. Oberlander further argues that Medicare's designers envisioned an expansionary role for the program that would result in an eventual turn to national health insurance, a plan that ultimately has failed to materialize. This is evocative of some of the recent proposals for addressing the problem of the uninsured, specifically those proposals that envision either an expansion by lowering the Medicare-eligible age or those that encompass opening Medicare enrollment to the uninsured directly.

Clinton Reform Effort and The Future of Health Care Reform

Jacob Hacker (1997), another of Marmor's students, produced what would likely be recognized as the seminal work on the politics surrounding the failure of the Clinton

initiative. Hacker's approach is largely based in path-dependence theory (which is also the theoretical foundation for this dissertation and more fully explored in Chapter Three), holding that the failure of the Clinton initiative was inevitable. Hacker (1998) also compared the decision-processes surrounding development of the medical systems of the United Kingdom, Canada, and the United States. In this article, also based in path-dependence theory, Hacker made the case that differences in the early decisions taken by the United States versus the other two countries had resulted in the other countries adopting universal health care while essentially shutting that possibility off from the United States.

Sociologists have also weighed in on the health care policy issue. Most notable among these are Theda Skocpol of Harvard, Paul Starr of Princeton, and Jill Quadagno of Florida State University. Skocpol's (1996) book on the Clinton initiative focused on a historical, and to a lesser extent structural, account of the conditions that led to the failure. She focuses structurally on the effects of the budget and the deficits incurred as a result of the Reagan tax cuts. In his review of Skocpol's book, Starr (1997), who worked inside the Clinton White House as an advisor following the disbanding of the President's Task Force, finds himself at odds to some extent with Skocpol's narratives. Though he does not completely disagree with Skocpol, he does turn completely away from her assertion that Clinton would have been better served by adopting a *more* expansive policy. Rather, Starr infers that he would have been more likely successful had he adopted a more incremental approach with smaller bites at the problem delivered more quickly. This is reminiscent of Wilbur Cohen's "salami slicer" approach (Cohen & McComb, 1968).

Starr's (1982) seminal work on the sociology of modern medicine likely set the stage for his involvement a decade later in the Clinton attempt. Starr (1995) places

himself in the chamber at Clinton's address to the joint session of Congress on September 23, 1993, and a year later when Senate Majority Leader Mitchell pronounced the bill dead. He called the period "one year from euphoria to defeat" (p. 20). The gist of Starr's argument is that the reform failed for three reasons: its long-term and extensive nature, failure to reach congressional compromise, and division among the Democrats in the Senate and House. He called for Democrats to devise a smaller program that would more quickly reach implementation. To date, his call has gone unanswered.

Quadagno (2005) provides a historical and sociological analysis of why the United States does not have universal health insurance. She places the issue in the context of a shift in the power structure inside the health care system itself. She points to an erosion of the cultural authority of physicians, a revolt among corporate purchasers of insurance benefits, and the rise of the managed care bureaucracy. Of these shifts, she says that the "changing composition of the antireform coalition dominated first by physicians and then by insurers and business groups, has obscured the persistence of stakeholder mobilization as the primary obstacle to national health insurance. Given the ever shifting scope of these debates, it is not surprising that many Americans find the health care issue too confusing to understand or resolve" (p. 11). While Quadagno's work expands the sociological perspective on the problem significantly, it begs the question of whether there is some economic point at which insurers and corporate interests might come to favor universal insurance—some Gladwell-like "tipping point" (Gladwell, 2002)—or will that point only give rise to another shift in the health care power structure?

Journalists have also provided insight regarding the Clinton initiative. Most notably, Johnson and Broder (1997) provided an extensive history of the failed Clinton attempt. Extensive, if not exhaustive, their *The System* provides a provocative, largely chronological account of the Clinton reform attempt, placing it in the broader context of

competing political and economic interests as well as clouds of scandal—from Travelgate to the Vince Foster suicide—that obscured the way forward on health care.

Political economist Sven Steinmo at the University of Colorado and Jon Watts, formerly a student at Yale University and the University of Colorado, provided an institutional perspective on reasons for the failure of national health care (Steinmo & Watts, 1995). In their oft-cited article, Steinmo and Watts argue that institutional bias, particularly in the face of an increasingly fragmented federalist political system, prevents the United States from achieving comprehensive national health insurance. Their historical account describes congressional reforms of the 1970s, which resulted in changes in both rules and committee structures creating a decentralization of power in the Congress that made passage of the Clinton initiative virtually impossible in their view. They conclude with an argument that this same institutional structure is a cause or contributor to American anti-government attitudes. On this last point, I am not yet convinced that the argument might not go in the other direction, i.e., the anti-government attitudes of Americans become reflected in the institutions. Perhaps this is a self-reinforcing mechanism.

A number of books have been published since the Clinton failure that have proposed various solutions to the health care problem. Three of these are considered most influential and have certainly been influential in my own understanding of the processes, though I find myself largely disagreeing with two of the proposals. Kotlikoff (2007) proposes a single-payer health *insurance* system. This differs from the traditional single-payer approach in that the federal government would pay the premiums for universal insurance to private for-profit insurers who would then manage the payment of benefits as claims. A more traditional single-payer approach would have the benefits paid for directly by the government. His work is excellent in illuminating the problem, but the

proposal is less than workable in its economic reductionist fashion. Kotlikoff fails to consider the insurance industry's potential unwillingness to cooperate with the proposal as the industry would incur increased underwriting risk under his proposed plan.

Herzlinger (2007) writes extensively about the causes behind the health care crisis. Her work is most valuable in its particular approach to focusing the blame. However, she proposes a "consumer-driven cure" for the problem which rests on free market principles. She believes consumers will automatically make the best choice (rational choice theory) based on maximizing benefit to themselves and, ultimately in Herzlinger's view, maximizing benefits to the market. Herzlinger essentially ignores the massive imbalance of information (and, as a consequence, imbalance of power) between consumers and providers in the American health care marketplace.

The third proposal comes from former Senate Majority Leader Tom Daschle (2008). Daschle's plan calls for establishing a politically independent Federal Health Board, similar to the Federal Reserve Board, which would be responsible for setting the annual health care budget. Daschle also proposes opening the Federal Employees Health Benefit Plan (FEHBP) to private employers as an alternative to other available plans and requiring employers to offer some form of basic coverage. Daschle's plan is likely the most economically feasible, at least of the plans with which I am familiar. Where his plan may fall short is in its continued reliance on the current model of primarily employer-sponsored insurance for workers and governmental or quasi-governmental plans for those not covered by employer-provided insurance.

HOW THIS WORK DIFFERS

While many have written about health care in America, from a variety of scholarly perspectives—historical, political, economic, and sociological—no one to my knowledge has specifically compared the two recent large attempts to address this

problem: Medicare/Medicaid and the Clinton Health Security Act. This is what I have attempted to do in this dissertation.

Equally importantly, by comparing these two efforts, which varied in outcome between success in 1965 and failure in 1994, I suggest some lessons on how to bring a solution successfully forward. With the Obama administration requesting $634 million for health care in the recently submitted budget, it is clear that federal health care policy is coming back into the spotlight now 15 years after the Clinton attempt failed. This is the time to try to understand how we, as a society, can act to reconstruct the role of health care in modern American society.

Finally, unlike Kotlikoff, Herzlinger, and Daschle, among many others, I do not espouse a particular model for providing health care coverage. Rather, I attempt to lay the groundwork for reaching agreement on a model, whatever form that the solution eventually takes.

SUMMARY

Today, American health care policy is largely a product of an employment-based system that experienced its first major impetus during World War II. As coverage under these plans expanded, and with the advent of Medicare and Medicaid, about 85 percent of the population now has some form of health insurance (Kaiser Commission on Medicaid and the Uninsured, 2006). This leaves a current uninsured population of 15 percent or 47 million Americans, however, composed primarily of the working poor (DeNavas-Walt, et al., 2007, 2008). Employer-based plans have shifted more and more of the costs of care to employees. Rising numbers of low-wage and part-time jobs have also contributed to the current rates of uninsured. Pricing policies have resulted in increased numbers of personal bankruptcies and lower usage rates of preventive services among the uninsured and underinsured. In spite of all this, total health care spending has risen dramatically and

is projected to double by 2016. A quadrupling of the national debt and dramatic increases in energy costs have led to a less-than-optimal economic forecast for the United States. The oncoming retirements of the first baby boomers, and an increasingly aging population with fewer workers to support non-working and retired persons, combine with anticipated increases in national health care spending to create a looming and nearly-immediate crisis condition. Perhaps these recent developments will open the path to more creative options.

The clear problem for this dissertation is to determine what are the necessary conditions for fundamental change of the health care delivery and payment systems in the United States. What can the example (Johnson) and counter-example (Clinton) tell us about the necessary conditions to achieve true universal coverage? Chapter Three focuses on the theoretical foundations and methodological underpinnings of this study as well as the orienting questions that drove both the research and the analysis of more than 11,900 pages of presidential documents spanning the two administrations.

Chapter 3: Theoretical Foundations and Methodology
The Path-Dependent Nature of Federal Health Policy

PATH-DEPENDENCE THEORY

Path dependence theory's social-science origins are in the study of economics, though, as with many social science theories, path dependence theory's original roots are in the physical sciences and, more particularly, in the realms of biology (evolution) and physics. The core of the theory is the idea that early decisions have greater impact on the eventual outcomes than later decisions. Furthermore, this impact is reinforced by positive feedback mechanisms that increase the attractiveness of the path. This is consistent with the causes of incrementalism as espoused by Lindblom and Woodhouse (1993), who held that rational choice theory was constricted by factors such as lack of information, factors of time, and costs of decisions. This serves to narrow the options available as the phenomenon of interest proceeds further down the path (Pierson, 2004).

Path dependence might best be analogized in the physical world to the climbing of a tree. At various points, decisions must be made about which branch to climb next. As the climber progresses further up the tree, the options to "jump" to another branch become more and more limited, and such a jump is increasingly difficult to make. Of course, one can always work one's way back to the trunk and take a new route, but the tendency of the climber is that whichever branch is chosen initially tends to be the branch (path) that is followed (Levi, 1997). An admittedly simplified illustration, as applied to United States health policy, appears in Figure 2 below.

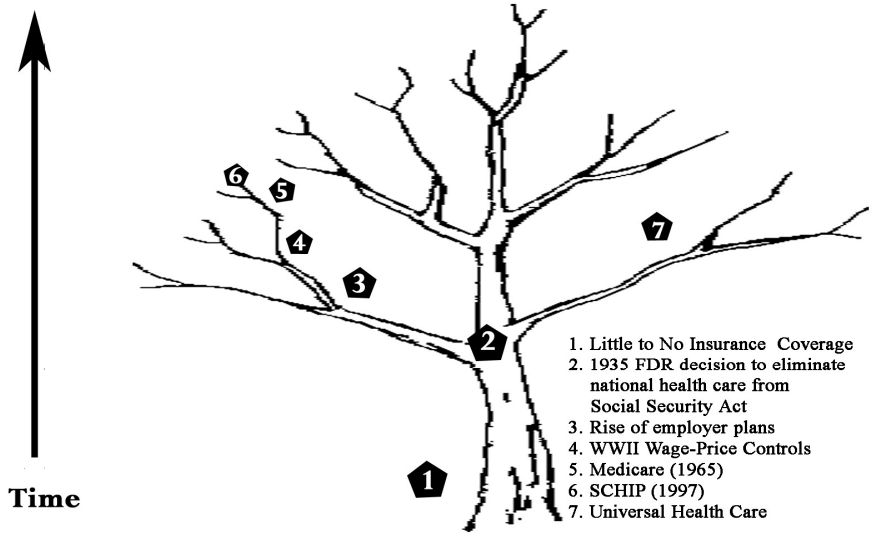


Figure 2: Simplified illustration of path-dependent effects on federal health policy

As the figure shows, decisions taken early in the sequence, such as FDR's decision not to include national health insurance in the Social Security Act took health care in a path away from universal coverage, even if this was not FDR's intent. The rise of employer plans and subsequent wage-price controls during World War II, which opened the way for a massive increase in employer-based coverage as a result of negotiations with organized labor, made the path back to universal coverage even more difficult.

Arthur (1994) points to four summary characteristics of positive feedback processes: unpredictability, inflexibility, nonergodicity, and potential path inefficiency. Unpredictability refers to the idea that early events, which are at least partly random, have large effects resulting in less predictability of the eventual end-state outcome of the path. Inflexibility refers to the narrowing of the path options as one proceeds further down the path, potentially leading to greater predictability of outcomes. It becomes increasingly difficult to shift to a different path over time, and decisions made earlier tend

to shift the path more than decisions made later. Nonergodicity implies that accidental events do not cancel each other out and cannot, therefore, be ignored as "noise." Even small events tend to be remembered in the path-dependent process. Potential path inefficiency results from the first three characteristics. Over the long run, the outcome that becomes established may be less desirable or efficient than other alternatives might have proven had they been selected earlier in the process.

To these four summary characteristics, Pierson (2004) adds the importance of sequencing – the idea that "history matters" (p. 18). Path dependence therefore takes into account the often slow-moving character of policy formation and the temporal forces that shape the narrowing of options and the eventual outcomes which may or may not be what rational actors would choose, a bit of a blow to rational choice theory.

This is not to say that rational choice theory is without merit. Indeed, much of modern economic theory finds its roots in rational choice, though increasingly this has led to game-theoretical models—relying on thought experiments to determine the best moves a given player will make so as to maximize his outcome—of decision making (Dye, 2007). Additionally, path-dependence models tend to move away from the cross-sectional nature of "new institutionalism" models (Hacker, 1997, 1998). Institutionalism generally holds that policy is the output of government institutions around which political activities take place. Therefore, analysis of the policy outcome, for the institutionalist, is rooted in the analysis of the regulating, promulgating, or legitimating institutions (Dye, 2007). Hacker, in fact, makes an elegant rebuttal to Steinmo and Watts' (1995) institutionalist view of the barriers to health care, such as constitutional design that encouraged factional politics to protect minority factions from majority oppression, Progressive Era reforms designed to limit corruption and the number of candidates for office thus strengthening the two-party system but creating barriers to entry for new

political parties, and generations of congressional reforms resulting in the need for supermajorities to break a Senate filibuster as an example. While Hacker does not discount the institutional barriers, he portrays them as also being the result of earlier decisions such as seniority systems and committee structures of Congress that have led to many available veto points for massive policy shifts.

Path-dependence theory does allow for paths to shift and new options or windows of opportunity to open at critical junctures (Hacker, 1998; Pierson, 2003, 2004). This is particularly helpful in this study, as the paths of some phenomena are closely intertwined with federal health policy (e.g., changes in the labor movement, cost shifting and other aspects of the employer-based model, medical inflation that outstrips consumer price inflation and wage increases, etc.). While these phenomena are guided along their own pathways, their paths are shaped by their dependence on other paths. As these paths converge, critical junctures may occur during which one path can be abandoned for another, more efficient, path or modified in a new direction as options previously restricted open, often only briefly.

What makes path-dependence theory particularly attractive is its longitudinal perspective. Much, if not most, social science is structured on reductionistic and cross-sectional methodologies. These methods value parsimonious and statistical explanations of phenomena under study. Such parsimony, and particularly cross-sectional methodology, constricts the ability to establish causality, which requires that the independent variable or variables not only co-vary with the dependent variable, but that they must occur *before* the dependent variable (Rubin & Babbie, 2005). Path-dependence theory permits the establishment of causal chains and potentiates the desirable predictive qualities of comparative historical research (Mahoney & Rueschemeyer, 2003; Pierson, 2003, 2004).

Path-dependence theory enhances the value of many other theoretical frameworks. It is entirely consistent with historical sequencing such as Neustadt and May (1986) espouse. It is capable of encompassing elite theory and can help to explain the constriction of elite behavior by mass political behavior and public opinion (Dye, 2007; Higley & Burton, 2006; Key, 1966; Mazmanian & Sabatier, 1980; Rochon & Mazmanian, 1993). As previously noted, it does not negate the value of institutionalism, but enhances it by permitting the exploration of the paths by which institutions develop, explaining the relative stability of older institutions, and allowing for prediction of how institutions might change in the future (Hacker, 1998). It is not only completely compatible with incrementalism, but it may help to explain why incremental change is prevalent.

Path-dependence theory, as applied to federal health care policy, would predict that the longer things stay the same, the harder they will be to change. For example, the nexus between employment and insurance established in the first half of the 20th century was reinforced by later decisions such as favorable tax treatment of employee benefit plans, wage freezes during World War II, and concomitant rise in union power. The societal expectation is set that the employer will provide health care for the employee. But as costs have risen, many companies have chosen to employ more people on a part-time basis to avoid having to offer expensive employee benefits. Companies have increasingly shifted costs to regular or permanent employees in the form of more premium sharing, higher deductibles, higher co-payments, and higher out-of-pocket maximums. The employer-insurance nexus is straining under these changes. Whether this will cause a limb to break is uncertain, though the path-dependence model would suggest that a critical juncture may be hurtling towards the American system.

Early decisions about Medicare payment structures—decisions that were made in the policy formulation stage—have contributed to rising health care costs. This, too, is predicted by the theoretical model. The early decisions to which I refer here surrounded utilizing private insurance companies to administer Medicare/Medicaid payments, as well as the "usual, customary, and reasonable" charge structures that created initial upward pressure on provider pricing. As private insurers often negotiate provider contracts on a basis of percentage-of-Medicare-approved charges, these early decisions have been reinforced.

Investments in infrastructure such as facilities, computer systems, personnel, and training in the private health insurance sector also tend to reinforce the status quo. This is clearly seen in the Clinton effort as the Task Force sought to appease the private health insurance companies and avoid potential destabilizing effects of a single-payer type of plan on the economy. Such a plan would have potentially led to hundreds or even thousands of employees being laid-off in the health insurance sector, though presumably some of these employees might be subsumed into the government to process payments. It would have led to downward pressure on stock prices in the financial sector. It might have led to bankruptcies of insurance companies, who are among the large lenders and investors who fund much of the market economy.

Taken together, these predictions might lead one to dismiss any possibility of major policy change toward a universal system of either coverage or care. That case has been made. Hacker (1997, 1998) utilizes just such an argument in his discussions of the failure of the Clinton health care initiative, implying that the path along which federal health policy had moved had so restricted future decisions as to make the passage of national health care reform impossible. Hacker (1998) goes a step further in using the model predictively when he says, "This reversal of fortune is perhaps the strongest

evidence yet that the United States has followed a fundamentally different path of health policy development than have other nations – one that will almost certainly not culminate in the passage of *European-style* national health insurance" (p. 124, emphasis added). In this, Hacker may or may not be correct, particularly if one takes note of the qualifying phrase *"European-style."* To the extent to which Hacker has ignored changes in the intertwined paths of employer-sponsored private health plans and significant increases in medical costs relative to the overall economy, his conclusion that the United States is "left facing virtually insuperable political barriers to the passage of national health insurance" (1998, p. 128) may be unwarranted.

Hacker (1998) does offer some measure of hope. He concludes that many have hailed the Clinton failure as the last great opportunity for health care reform, a point with which he disagrees, but only to the extent that "the right combination of interests, ideas, and leadership can create possibilities for policy innovation where reformers once thought none existed" (Hacker, 1998, p. 182). The goal of this dissertation is to examine two critical points on the historical path, the processes that occurred at each of those points, and the lessons to be learned in preparation for the time when Hacker's "right combination" comes to fruition.

METHODS

Comparative policy development analysis, a combination of retrospective and prospective approaches that focuses on the development process rather than the policies *per se*, has experienced a resurgence in the past decade. It is broadly seen in the social sciences as a method of addressing the less satisfactory cross-sectional models of policy analysis that continue to dominate the intellectual discourse. Methodologies continue to arise that improve the scholarly rigor of comparative policy analysis studies, provide useful frameworks for building such analyses, and speak to the usefulness, if not

generalizability, of comparative policy development analysis (Mahoney & Rueschemeyer, 2003; Pierson, 2004).

I have utilized a hermeneutic approach to case analysis as my method (Creswell, 1998; Diesing, 1991; Lejano, 2006). I have relied on the direct documentary evidence of the Lyndon Baines Johnson Library and the Clinton Presidential Library archival holdings, at least to the extent that relevant holdings have been made available. I have also examined the relevant files of Congressman Wilbur Mills from his archives held at Hendrix College in Conway, Arkansas. I have examined an estimated 16,000 documents, selecting more than 11,900 pages of documents from these three primary document sources to be photographed or photocopied for study outside the archival settings.

I used the relevant literature surrounding both initiatives as well as federal health policy in general to formulate a basis for understanding the two presidents, First Lady Hillary Clinton, and the other major players involved in these efforts. I also relied on extensive oral histories, most unpublished, from the LBJ Oral History collection. These provided insight into at least how the players contemporaneously viewed themselves and the other critical players in the efforts of the times. This grounding is in line with Lejano's (2006) approach to validity. Lejano suggests that such interpretations must be grounded in the context of the time, other literature and interpretations as available, and the interpreter's knowledge of the authors of such texts, documents, or artifacts.

Prior to entering the archives, I prepared myself for the initial phases of the documentary research by contacting the archivists and obtaining either e-mailed copies or links to online copies of the extensive finding aids from each of the archival depositories. I studied these aids and marked the boxes and folders which would be most relevant to my study. I then met with the archivists at both presidential libraries for training in how to request, handle, and photograph or photocopy the documents. The presidential archives

require scholars to complete this training prior to utilizing the archives, and the training is certified by a researcher identification card issued by each respective presidential library.

Having received the training at the Lyndon Baines Johnson Library, I requested document boxes and began reviewing the documents. Because I lived in Austin during the time I was conducting this study, the LBJ Library is convenient enough that I was able to do an initial triage of each box. This entailed examining each document and deciding whether it was of enough interest to photograph. The library provides a system for scholars to index and then photograph documents free of charge. This makes storage easier and is considerably cheaper than photocopying. The Clinton Presidential Library had no such arrangement. Consequently, I created my own copy stand and tripod arrangement and obtained permission to use it to photograph the Clinton documents. Due to travel costs to Little Rock for the Clinton part of the documentary research, I did much less triage on the documents as I was handling them (unlike the LBJ case). For this reason, I have about twice as many Clinton document photos as I do of the Johnson documents, in spite of the fact that there are many more Johnson documents available. The result is that I now have full-size photographs of approximately 7,300 pages of documents from the Clinton Library. I also have about 300 hard copies of Clinton Library documents from my first excursion there and about an equal number of scanned copies, for a total of about 7,900 pages. I have about 4,000 from the LBJ Library.

Additionally, I have visited the Wilbur Mills Archives housed in the Hendrix College Archives in Conway, Arkansas. During my visit there, I was able to triage all the files relevant to the passage of Medicare and Medicaid. Judy Robinson, the Hendrix College archivist, very kindly copied all the documents which I selected and subsequently sent me the hard copies. There are about 300 pages of documents from the files of the late Congressman.

All of the digital documents have been processed into formats that are easily viewable and readable. I have developed a dual-monitor system that permits me to view the document on a vertical monitor while noting those documents that are of most importance on a database on the other monitor. I have shot pictures of many more documents than are directly relevant to the actual political processes. I did this for two reasons: 1) I hope that I may be able to utilize these documents in further research beyond the dissertation; and 2) with limited time and resources when traveling away from home, it is much quicker and less expensive to photograph entire boxes of documents in one trip and triage them later.

Bearing in mind the path-dependence model on which I had based my predictions, I created a database encompassing all of the documents which I had photographed or photocopied from the archival depositories. Included in the database were the location of the document, box number, folder number or identifier, date of the document, creator(s) of the document if known, recipient(s) or intended recipient(s) of the document if known, a temporary notation of the importance of the document, and contemporaneous notes of my impressions, the document topic, and any other relevant information that would assist me in reviewing the documents at a later date. I also included the computer directory where the document could be found in my storage system and the numerical photograph file name (or range of names, in the case of multiple page documents) so that I could quickly retrieve any document in the database.

After all documents had been catalogued, I reviewed each database utilizing a triage system based on the ranked importance of the documents. I first read all documents which I had classified as “Extremely Important,” followed by those that were “Very Important,” or “Somewhat Important.” I briefly reviewed those documents which had been classified as “Important for later use” to ensure that I was not leaving out any of the

major points to be determined from the archival documents. Finally, I briefly reviewed those documents that I had originally ranked as “medium” or “low” in importance. As I reviewed documents, I expanded the notes as necessary which gave me, in essence, a field journal of the research (Creswell, 1998).

Having completed my review of the documents, I compared my notes to various sources from the literature seeking from reports of interviews done by other scholars as well as their interpretations, some of them contemporaneous to the events, to assist in my interpretation of the documentary evidence. At times, I was able to confirm other reports. Occasionally, my reading of the source documents conflicted with other reports. In other cases, my interpretation of the documentary evidence expanded upon the earlier interpretations of documentary and other evidence offered by other scholars. In this way, I triangulated my findings against the work of known and recognized scholars (Diesing, 1991; Lejano, 2006).

Based upon the resulting, and considerably narrower, selection of documents, I utilized a case study comparison and contrast approach, as set forth by Creswell (1998), to reconstruct important events, conversations, and correspondence in the process. Utilizing the triaged documents and database, I initially read through the documents to get an overall sense of the case, making additional notes during this reading. Gaps in the record were noted and, to the extent possible, I drew tentative conclusions from the surrounding documentation regarding the gaps. Such an approach to gaps in the record is generally-accepted in historical analysis (Diesing, 1991; Neustadt & May, 1986; Pierson, 2004). Finally, I developed naturalistic generalizations.

Rigor in the case study tradition relies upon one or both of two strategies: member checking and triangulation. For this study, I utilized triangulation to improve the scholarly rigor of the study. Comparison of the actual historical record to events as

outlined in the literature, including memoirs of the various political actors; journalistic reports of the relevant periods; and previously promulgated theories about the outcomes of the two legislative initiatives provided the required triangulation to confirm the naturalistic generalizations drawn from the case studies of the two periods. Additionally, I utilized the criteria of cohesiveness, utility, triangulation, and study balance put forth by Stake (1995).

I developed a narrative for each of the two administrations, including description of the times, settings, main players, and their activities, processes utilized by the players to move their activities forward, and patterns of meanings. Stake and Kerr (1995) state that "[T]he change in respect for naturalistic case study findings has been almost paradigmatic…Increasingly, personally constructed knowledge is seen not only as credible evidence but as the *product* of good research" (p. 55, emphasis in original).

Public opinion polling data from both periods are available from The Gallup Organization. I acquired a subscription to The Gallup Brain which gave me access to polling results from 1935 forward. Unfortunately, Gallup has now discontinued this subscription-based product and access is no longer available. Specifically, I concentrated on Gallup's "Most Important Problem" (MIP) surveys which have been conducted several times annually since 1935. To the extent that data were available, I examined additional polls directly related to health care. Health-care specific polling data were available for the Clinton era but not the Johnson era.

The Lyndon Baines Johnson Library web site has online search capabilities for recordings of White House telephone conversations from the Johnson administration. These recordings are largely available online through the Miller Center for Public Affairs at the University of Virginia. Using the LBJ Library search engine, I located 67 conversations referencing Medicare. I listened to each of these conversations seeking any

additional evidence of the paths and processes President Johnson took to pass Medicare and Medicaid.

Finally, I utilized the ProQuest databases of *The New York Times* and *The Los Angeles Times* to acquire data on articles on pending health care initiatives for the respective periods in an effort to assess the degree of media attention given to the two initiatives. Although I have chosen to base this analysis in McCombs' (2004) initial stage of agenda setting (capturing public attention), which does not require an examination of the valence of the coverage, I have elected to examine the relevant editorial content of the two newspapers to formulate some understanding as to the editorial positions taken during the two periods relative to the two legislative initiatives.

Scholarly pursuits by their nature are subject to the scholar's biases. Qualitative inquiry is perhaps particularly vulnerable to bias. Scholars strive to minimize bias to the extent possible, and one important step in doing so is to acknowledge any particular bias towards the subject matter (Creswell, 1998). Having said that, scholars have come increasingly to formally recognize the importance of personal experience as a component in the creation of knowledge While the AMA would eventually withdraw its support for a national health care plan, social workers were there during the early days of the progressive movement, actively worked with the AALL (Kreader, 1988). In respect of both viewpoints, I offer the following statement regarding my own biases in the matter of health care policy and the experiences which have brought me to my view of the importance of this study.

As a social worker and a progressive, I am biased in favor of universal health care. Having spent more than 11 years of my pre-social work career in the insurance and investment industries, I am keenly aware of the inner workings of those industries. This knowledge has the potential to bias my perspectives. There are many ways to achieve

universal access to health care. Some of these ways involve utilization of current institutions and structures for provision of care, specifically insurance companies or government-backed insurance models. Others involve more direct payment and provision of services by the government itself. Having examined my own ideas about these means and methods, I find that I have no single bias as to how universal health care should be accomplished. Rather, I think that it could reasonably be accomplished in a number of ways.

Social work as a profession espouses principles of social and economic justice, and strives to improve the lot of the oppressed and underrepresented members of society. Many, though certainly not all, social workers see the present state of health care in the United States as representing a certain level of economic and social injustice. I place myself among that group. However, because of my extensive background in the private sector prior to entering the study and practice of social work, I bring a business point-of-view to the problem in addition to the social and economic justice models. Universal health care, in my admittedly biased view, is not only the moral thing to do; it is also the prudent course from a business and economic perspective. Achieving agreement on universal health care will not likely be accomplished solely on the strength of the moral argument for economic justice. More likely, it will have to be sold on the basis of the economic soundness of the idea. That bias on my part is likely to inform at least the last chapter of the dissertation, which addresses moving the universal health care policy agenda forward.

Finally, and in a larger sense, I contend that bias is a necessary ingredient for the valid exercise of hermeneutic interpretation of texts and artifacts. Gadamer (1960, as cited in Lejano, 2006) holds that such bias, so long as it does not fatally restrict other interpretations and meanings, is necessary to the interpretation process.

Diesing (1991) makes a similar case for the importance of bias and against scientific neutrality in the hermeneutic approach:

> The hermeneutic approach does not require detachment or neutrality of the scientist. It requires involvement, even participation in the culture of the author. Indeed, it denies that neutrality is possible. Interpretation is an active process that begins with foreknowledge and is limited to the ideas interpreters can think and the contextual material they can find. Interpreters necessarily bring their own way of thinking to the text, and their interpretations express their experience as well as the meanings implicit in the text. (p. 122)

Diesing (1991) also believes that such active engagement in interpretation "contrasts sharply with the scientific detachment or neutrality postulated by logical empiricism" (p. 124), and attributes disagreement between the two traditions at least partially to this contrast.

Based on these ideas, I have attempted to ground my interpretations in their appropriate temporal and political contexts through use of the literature relating to both eras. I bring to bear my own past knowledge and experience, which arises out of more than 20 years of business experience, with over 11 years directly in the insurance business. In those capacities, I have experience in the purchase of both employer-based group health insurance and individual policies. I also have an insider's understanding of the product structure of health insurance as well as the business and cultural ideologies that have shaped that structure. It is my hope that these experiences—including the extent that they might be seen as biases—will enlighten my interpretations of the various texts and presidential documents in ways that are appropriate and that do not represent fatal dismissal of alternative interpretations (Lejano, 2006).

APPLYING THE THEORETICAL MODEL TO DETERMINE THE ORIENTING QUESTIONS

In the early 1990s, political scientists began to adapt the methods of comparative-historical analysis primarily to study the rise of societal institutions such as the welfare state and national health care. The critical juncture framework of path dependence holds that early decisions or antecedent conditions limit the agency of political actors during critical junctures and thus favor particular trajectories of institutional development (Collier & Collier, 1991). Some scholars argue, however, for a model of industrial evolution in which key actors constantly renegotiate institutional configurations and missions (Streeck & Thelen, 2005). This is not inconsistent with punctuated equilibrium theory, which holds that policy shifts gradually with policy change punctuated by changes in institutional conditions such as party control of government, shifts in public opinion, or exponential growth of institutional influence (e.g. the media). Punctuated equilibrium theory arose from Darwinian biological theory, as adapted initially by Baumgartner and Jones (1993).

Paul Pierson (2004), a political scientist, was an early adaptor of the path-dependence model as it related to political economics and health care in particular. Pierson (2003; 2004) points to the need to understand temporal processes and proposes four types of time horizons for causal accounts. The four are divided along a matrix based on the time horizon of the cause versus the time horizon of the outcome (see Figure 3). The health policy reform phenomenon fits best in what Pierson refers to as Type III, which he compares to the natural pattern of earthquakes: that is a phenomenon in which the time horizon of the cause (building pressure beneath the earth's crust accompanied by slow movement of tectonic plates) is relatively long while the time horizon of the outcome (the actual quake) is relatively short. Pierson (2003, 2004) further emphasizes the importance of the sequence of events in a path-dependence model. Based on the path-

dependence model and Pierson's time horizons approach, I developed the orienting questions for this study.

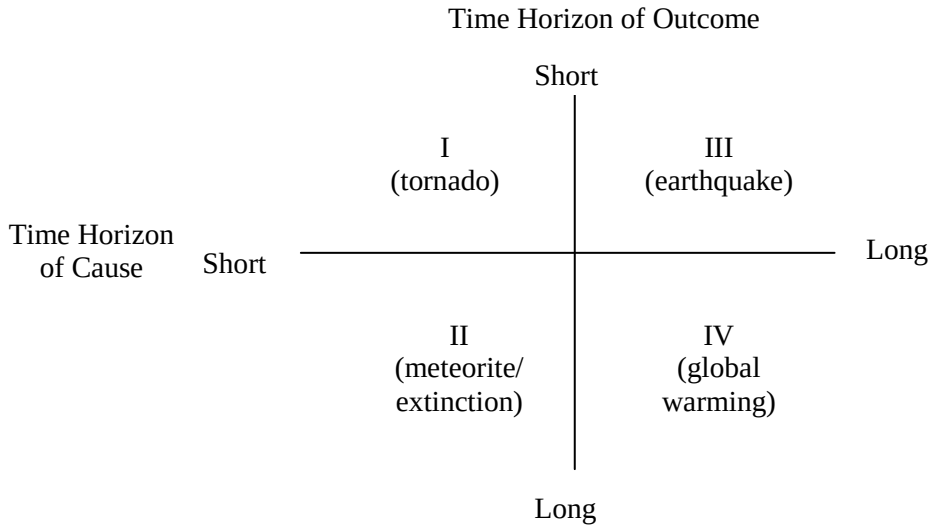


Figure 3: Time Horizons of Causal Accounts [adapted from Pierson (2004)]

ORIENTING QUESTIONS

Accepting the explanatory potential of the path-dependence argument (Arthur, 1994; Hacker, 1997, 1998; Hacker & Pierson, 2005; Pierson, 2003, 2004), four orienting questions, based on this model, directed the comparative policy development analysis of the Johnson success and the Clinton failure. These questions are:

1) Relying on a modified approach based on Arthur's (1994) path-dependence model:

a) what historical factors, including political, economic, and direct health policy components, set the stage for the respective success and failure of the Johnson and Clinton health care policy initiatives,

b) were those factors natural, accidental, or planned, and

c) in what sequence did they occur to facilitate the respective outcomes?

2) To what extent did the two presidents, their staffs, and legislators of the two time periods act to foment or facilitate these factors, and, in the absence of any such direct action, in what ways did they react to or utilize these factors in pushing for passage of the respective presidential health care policy initiatives?

3) What were the barriers to legislative passage, and what steps, if any, did members of the respective administrations, legislators, and policy activists such as social workers take – or should they have reasonably taken – to overcome these barriers?

4) To the extent that conditions have changed since the 1990s, what can social workers and allied policy activist groups do to:

a) hasten the process of health care reform by reducing political barriers;

b) recognize opportunities to advance reform initiatives;

c) prepare for swift action when the path to new policy change options opens; and

d) utilize strengths of the social work profession (e.g., case management, clinical skills, advocacy skills) to ease the transition to national health care if and when that time arises?

PATH DEPENDENT DOMAINS TO BE EXAMINED IN FEDERAL HEALTH POLICY

Having provided a rationale for path-dependence theory as the model of choice for this comparative policy development analysis, it is now necessary to delineate the domains I will examine in attempting to answer the four orienting questions above, as well as the methods by which I will examine these domains and their influence on the paths the United States has taken and the outcomes to date of these paths. The final chapter will incorporate the changes in these paths and variables post-Clinton with an

attempt to predict the necessary critical junctures and recommendations for capitalizing on them when the path reopens to a policy shift for federal health policy.

The first three orienting questions lend themselves to examination in three primary domains of study: historical, institutional, and political. These three domains influenced outcomes in both the Johnson and Clinton administrations, and will undoubtedly further influence any new attempts at national health care reform.

Historical Domain

Consistent with the current state of the literature (Hacker, 1997, 1998; Hawthorne, 2007; Lakoff, 2004; McCombs, 2004, 2005; Steinmo & Watts, 1995), I will examine historical developments in American social welfare policy including: a) workers' compensation insurance and Social Security; b) attempts to pass a comprehensive federal health policy between the passage of the Social Security Act of 1935 and the Johnson initiative; c) post-Medicare developments in health care costs, policies, and reform attempts; and d) the rise in inequality and other factors that have influenced health insurance programs and coverage of the American population between the Johnson Administration and the Clinton Administration. This domain will rely on historical accounts in the extant literature interpreted as they apply to the health policy path, recognizing that the Clinton era opens with a path dictated not only by the sequence of events prior to the Johnson era, but the effects of Johnson era policies and other changes between the two periods.

Institutional Domain

The institutional domain refers to the legislative environment and the influence or leadership the two presidents exerted in response to the respective legislative environments of the time. The majority of this analysis rests in the thematic analysis of

relevant documents from the respective presidential archives. To establish the rigor of the analysis, I utilized triangulation with the literature concerning the two presidents and the respective periods, i.e., I compared the findings from the source documents to the results of previous studies of the phenomena of interest. I give specific attention to the following dimensions of the institutional domain:

1*) Legislative tempo*, particularly the amount and type of legislation sent to Congress by the respective presidents.

2) *Positioning strategies* of the respective administrations with respect to the media, special interest groups, and members of Congress. These strategies include attempts at setting public expectations, strategies for controlling or influencing the media, and strategies for "marketing" the administration and its policy initiatives in the best possible light.

3) *Perceived level of engagement of the respective presidents* in the legislative process. This picture will be more complete for LBJ than for Clinton given the considerably higher availability of direct records in the LBJ archives. However, correspondence files in the Clinton archives, and particularly in the Chris Jennings series, should give some insight into President Clinton's involvement in the process and can be compared to historical accounts from members of the administration, the Clintons themselves, and journalists of the time.

4) *Prioritization of policies* by the respective administrations, especially as compared to the priorities and stakes for the opposition party. Effects of the legislative priorities will be of particular interest in the negotiation of the outcomes. In particular, trade-offs between party interests (e.g., tax cuts versus expanded social programs) inform these analyses.

5) *Outside factors* (e.g., economic conditions, budget constraints, Vietnam war) that may have influenced the outcomes and how their influence was manifested.

Political Domain

The political domain comprises the dimensions of public opinion, media influence, and influence exerted by special interests. This analysis will be largely based in available public records and accounts from the time period including opinion polls, media accounts, and influences from both the public and the media as well as special interests as reflected in correspondence files of the respective administrations. I specifically examine the following areas in the political domain:

1) *Role of public opinion / public attention* in policy formation and legislative processes. This will be further informed by agenda-setting theory (McCombs, 2005) and an inquiry into the role of the media in setting the public agenda for the two periods. Agenda setting deals with the focus of media and public officials' attention on the identified problem, according to Dye (2007). McCombs (2005) proposes a generalized theory of agenda setting that seeks to explain the relationships between the mass media and public opinion. However, he stops short of analyzing the impact of the agenda set by this interaction on the institutions charged with formulating and passing the required legislation to bring policy to action. This analysis will incorporate data from the Gallup Organization's Most Important Problem Questions, which have been asked several times per year over the last 70-plus years.

2) *Relationship of media attention to legislative outcomes*. Based in McCombs' Agenda-Setting Theory (McCombs, 2005), this analysis relies on counts of articles from *The New York Times* and *The Los Angeles Times* newspapers utilizing the ProQuest search engine available from the University of Texas at Austin Libraries web site for each of the respective periods, as well as the valence of the articles, i.e., for or against the

President's health care agenda.. (I had initially anticipated also using the databases for *The Washington Post* as provided by ProQuest, but the database stops in 1990 making a comparison between the same databases unavailable.)

3) *Influence of special interest groups*, including the American Medical Association, the health insurance industry (as represented by the Health Insurance Association of America), organized labor, business interests, and political action committees (PACs). This analysis is grounded in both McCombs (2005) methods and Lakoff's (2004) work on framing the debate.

SUMMARY

Utilizing case-study techniques and comparative historical analysis, I developed case studies of the two presidents, the paths on which they found themselves as they attempted to shift federal health policy, and the means and methods they employed in their respective attempts. I have incorporated quantitative analyses into these narratives to the extent that they help to illuminate the path. To the extent possible, I drew preliminary causal inferences from the path-dependent analysis and used them to develop predictions about the path ahead.

Chapter 4:
The Path to Medicare and Medicaid

EARLY ATTEMPTS AT NATIONAL HEALTH CARE THROUGH FDR

The first attempts at a federal health policy began during the early days of the Progressive Movement. Of particular note was the passage of Workers' Compensation laws in 1908, covering workers who were injured on the job and paving the way for further health insurance reforms. As Great Britain and Germany adopted national health care programs, pressure increased on the United States to take similar action (Hacker, 1998). Emboldened by passage of the worker's compensation legislation, many of the supporters worked together on national health reform. By 1915, the Standard Bill, result of these efforts, was finalized and proposed by the American Association for Labor Legislation. The American Medical Association as well as the National Association of Manufacturers initially supported the Standard Bill. However, as interest waned in the Progressive Movement, fractures began appearing between various labor constituencies and other groups, such as the AMA, which had shown support for some sort of national health care (Goldfield, 1992; Weathers, 2004).

By the time Franklin D. Roosevelt took office as President, the country was embroiled in the Great Depression. Soup lines and bank failures marked the times as unemployment rose nationally. Leading up to this point, reformers in the late 1920s were already pushing for health care cost containment. Roosevelt inherited an economic collapse of Biblical proportions. As the economy struggled toward recovery, the plight of the elderly poor and the disabled became a paramount concern. This led to the passage of the Social Security Act of 1935. Roosevelt wanted to include health care in the act but was dissuaded by his advisors who thought it would be too difficult a sell and would

jeopardize passage of the income components of the act (David, 1985; Marmor, 2000; Weathers, 2004).

THE TRUMAN ATTEMPTS (1945-1953)

In April of 1945, Harry Truman became President when FDR died in office. Truman advocated a cradle-to-grave approach to national health care that also included an expansion of medical education and training. This plan was embodied in the Wagner-Murray-Dingell health bill, first proposed in 1943 and supported by FDR. The Wagner-Murray-Dingell bill, in one form or another, was introduced every year for more than a decade (David, 1985). The bill garnered unlikely but fervent support from the former assistant chairman of the Republican National Committee Albert Lasker and his wife Mary, a well-known philanthropist with high regard for medical research and a strong belief in the need for national health insurance. She urged her advertising-magnate husband Albert to throw his support behind national health insurance. The Laskers gave more than financial support to the effort, lending their considerable political network to the task. The Laskers felt that the Republican bill offered by Sen. Robert Taft of Ohio, which included medical care for indigent people only, was insufficient and closer to a model of state-controlled medicine (Furman, 1947).

Truman's enthusiasm prompted reformers to move away from pursuing state-funded programs towards a nationally funded but state-administered program–much like the present Medicaid program. Truman's goals also reflected a change in focus from the efficiency arguments of the Progressive Era towards one rooted in post-war prosperity. Simply stated, Truman felt that the United States could afford national health insurance. Unfortunately, he apparently underestimated the magnitude of the opposition and the plan failed to materialize during his presidency. Opposition from the AMA, ostensibly over a perceived threat of government intervention in the doctor-patient relationship, and other

organized interest groups did not abate in spite of Truman's attempts. Grassroots supporters of national health care remained poorly organized and ineffectual. Truman took his surprise re-election in 1948 as a mandate and refused to compromise his vision of how national health insurance would work. Massive advertising campaigns and "red-baiting" were hallmarks of the opposition (Starr, 1982; Weathers, 2004).

Though the election of 1948 had provided an increase of 75 Democrat seats in the House of Representatives, most of Truman's domestic agenda was thwarted by "a coalition of anti-Truman Southern Democrats and Republicans" (Marmor, 2000, p. 8). Truman would not prevail. However, during this same time, the number of Americans with voluntary and privately-owned health insurance increased from 12 million to about 32 million Americans (Campion, 1984). Labor unions saw such plans as desirable features of compensation contracts and the trend toward the United States' current employer-based system was on its way. In the latter years of his presidency, Truman begrudgingly floated a narrower proposal – expansion of health coverage to old-age and survivor beneficiaries under Social Security. Stymied again by the AMA and other special interest groups, Truman would not even see this more limited vision realized until 1965 when LBJ signed Medicare into law at the Truman Presidential Library with the former President in attendance (David, 1985; Weathers, 2004).

THE EISENHOWER YEARS (1953-1961)

There is little of note during the Eisenhower Administration with regards to any attempt at national health care. Apparently Ike focused his efforts elsewhere. This is not to say that Eisenhower failed to take a stand on health insurance. Indeed, he took an active stand – against national health insurance. According to Marmor (2000), "Even when the Democrats regained control of the Congress in 1954, the partisan majority did not comprise a favorable Medicare majority. In fact, the legislative prospects were so

slight that no committee hearings [on national health care] were held until 1958" (p. 23). In 1958, as the drive towards Medicare began heating up in the Congress, Eisenhower remarked: "If all Americans want is security, they can go to prison. They'll have enough to eat, a bed, and a roof over their heads" (U.S. Congress, 1958, p. 8, as cited in David, 1985).

In 1957, Congressman Aime Forand (D-RI), at the urging of organized labor leaders, introduced a bill drafted by I.M. Falk and Wilbur Cohen. Organized labor gained increased strength when, in 1955, the American Federation of Labor (AFL) and the Congress of International Organizations (CIO) joined forces. Labor's concern was that most private insurers would not offer coverage to those aged 65 and older; pensioners were retiring without the medical coverage they had enjoyed while actively employed. Forand was initially reluctant to introduce the bill, thinking it would be an exercise in futility. As grassroots support quickly grew; however, he became an ever more ardent advocate of the legislation. Though the bill had no chance of passage or even of being reported out of the Ways and Means Committee, Forand did accomplish his goal of getting a written record started through hearings that he essentially forced Wilbur Mills, Chairman of the House Ways and Means Committee, to call. Mills, however, refused to attend the hearings and Forand was forced to chair the hearings himself. Still, some 720 pages of record were created. Ultimately, the bill was defeated in the Ways and Means Committee by a 17-8 vote in 1959 (David, 1985; Marmor, 2000).

Initially, the Forand Bill had no corresponding legislation in the Senate. However, acting on his own initiative, Senator Wayne Morse (D-Oregon) introduced the bill in the Senate in February of 1959. Later that same year, at the urging of Senate Labor Committee staffer William Reidy, a University of Wisconsin classmate of Wilbur Cohen, Chairman Lister Hill (D-AL) formed the Subcommittee on Aging. Reidy and his staff

colleagues wanted the committee's youngest member, John F. Kennedy (D-MA) to chair the subcommittee. Ted Sorensen, Kennedy's assistant, initially turned Reidy away when he proposed the idea. Why Sorenson did so is not clear. However, Myer Feldman, another Kennedy aide, liked the idea very much and promised to take it up with Kennedy. Meanwhile, Pat McNamara (D-MI) heard about the subcommittee and lobbied Chairman Hill for the subcommittee chairmanship, which he obtained. Kennedy was named to the committee, along with several others including Republican and long-term Medicare opponent Everett Dirksen (R-IL) (David, 1985). McNamara took the subcommittee on a seven-city coast-to-coast tour that started in Boston on October 13, 1959 ("INQUIRY ON AGED OPENS: 2 Senators Start 7-City Tour With Hearings at Boston.," 1959). Each hearing was heavily attended by both public and press, and the hearings were opened to comments from the floor. Ultimately, the effort failed to pass the Forand Bill, but the record now included these important grassroots hearings and McNamara's report to the full committee (David, 1985).

Meanwhile, Kennedy had delivered his Ten-Point Program on Old Age to the Senate in August of 1958, written by Myer "Mike" Feldman, Ted Sorensen, and Wilbur Cohen. In 1959, Kennedy and Senator Philip Hart (D-MI) co-sponsored a bill similar to the Forand Bill but with an extended number of days of benefits. The Forand Bill (S. 881), sponsored by Morse, was joined by the Kennedy-Hart Bill (S. 2915), which was sent to the Finance Committee. Both bills ultimately failed, but the Ten-Point Program and the Kennedy-Hart Bill established Kennedy's interest in issues of the elderly, and in medical insurance for the elderly, in particular. Only jobs and housing ranked higher than medical insurance in the Ten-Point Program (David, 1985).

In early 1960, hospital and nursing home care comprised more than half of the federal government's $514 million in total outlays for medical payments. These payments

had grown out of the Social Security Amendments of 1950 which, for the first time, authorized so-called "vendor payments" for welfare services. In other words, the amendments permitted federal and state governments to make payments directly to institutional providers, including hospitals and nursing homes, for the provision of so-called "charity care." These payments, however, were dependent upon patients meeting local and state eligibility tests. In spite of a decade of such payments, ten states (mostly Southern states), had no provisions for vendor payments for medical care. This set the stage for Public Law 86-778, the Kerr-Mills Act of 1960, forerunner of today's Medicaid (David, 1985; Marmor, 2000). The philosophy was to give grants-in-aid to the various states based on a complicated cost-sharing formula, and to allow the states to decide a) whether to participate in the plan at all and b) if it did, what specific services the state would cover for its medically indigent population (David, 1985; Weathers, 2004)

Wilbur Mills initially proposed the bill during hearings in the Ways and Means Committee on the Forand Bill and the amendments to Social Security. The Mills plan required neither new infrastructure nor any new social philosophy for its implementation. Rather, it utilized the existing system and put the administrative burden, as well as substantial cost-sharing burdens, back on the states, should they choose to adopt them. The bill was quickly reported out by the Ways and Means Committee; the House passed it on June 3, 1960 (David, 1985; Weathers, 2004).

Senator Robert Kerr (D-OK) was looking for a way to distinguish himself from the Democrat nominee for President, John F. Kennedy, a Catholic who was almost certain to lose Oklahoma on religion alone. Kerr sought Wilbur Cohen's counsel to draft a bill that was similar to the Mills bill but which would particularly benefit Oklahoma in the way in which costs would be shared. In the case of both bills, the federal government would supply between 50 percent and 80 percent of the funds. The respective bills were

passed and then reported out of conference quickly on August 24, 1960, as part of the Social Security Amendments of 1960. The House approved the conference report on August 26 and the Senate on August 29. President Eisenhower signed the bill into law on September 13, 1960 (David, 1985)

Among progressives, the primary objection to the Kerr-Mills bill was the state-administered means test, which was seen as demeaning to recipients and therefore likely to indirectly restrict access to the needed care. Essentially this test would require individuals to declare themselves "medical paupers" unable to pay their own medical bills while too well off to qualify for welfare. In spite of the demeaning means test, Wilbur Cohen, often described as an incrementalist, supported it as a step toward Medicare. Aime Forand reacted to the bill with disgust. Pat McNamara, chair of the Senate Subcommittee on Aging remained equally unconvinced by Cohen's efforts on behalf of the Kerr-Mills Bill (David, 1985; Marmor, 2000). McNamara saw the plan as being unlikely to do either much harm or much good. In this he was borne out by the facts. While the bill's sponsors and other supporters saw it as a way the states could offer those benefits which they deemed most important for their own citizens, by the time Eisenhower left office, only Michigan, Oklahoma, Massachusetts, Kentucky, and West Virginia had passed legislation providing for at least some of the authorized benefits (David, 1985). By 1963, three years after its passage, 32 of the 50 states had adopted plans under Kerr-Mills, but five states—California, New York, Massachusetts, Michigan, and Pennsylvania—representing 32 percent of the population over age 65 were receiving nearly 90 percent of the funds available under Kerr-Mills. In spite of these results, both Kerr and Mills advocated on behalf of the efficacy of the bill (Marmor, 2000; Weathers, 2004).

The net effect of Kerr-Mills may well have been to delay Medicare by another five years. Cohen would be proven right in the end, at least with respect to the bill's being a step toward the eventual passage of Medicare, as the principles behind Kerr-Mills, i.e. means-tested state-administered plans for the poor, would become the foundation for Medicaid under the Social Security Amendments of 1965.

MEDICARE IN KENNEDY'S NEW FRONTIER

In 1961, John F. Kennedy assumed the Oval Office, having defeated Eisenhower's Vice-President Richard Nixon by the slimmest majority to date in the history of U.S. presidential elections. This did not prevent Kennedy from pursuing an ambitious agenda, which would include tax, trade, housing, and foreign aid bills among its high-priority initiatives. If they were to be passed, all would need to be reported out of Mills' Ways and Means Committee (Marmor, 2000). On January 30, 1961, Kennedy delivered his first State of the Union address to Congress. In the message, he addressed the recession under which the economy was laboring at the time. He spoke about foreign policy and domestic problems at home. Regarding medical care for the elderly, he said:

> Medical research has achieved new wonders – but these wonders are too often beyond the reach of too many people, owing to a lack of income (particularly among the aged), a lack of hospital beds, a lack of nursing homes and a lack of doctors and dentists. Measures to provide health care for the aged under Social Security, and to increase the supply of both facilities and personnel, must be undertaken this year. ("Transcript of the President's First Report to Congress on the State of the Union," 1961)

On February 9, Kennedy sent his message "Health and Hospital Care" to Congress, the first special presidential message to Congress in history devoted entirely to the need for a health care program. In it, he particularly noted that the annual medical bill of persons over age 65 is likely to be twice that of the younger populations while the income of the elderly is only half that of the younger population (David, 1985).

The Kennedy Administration's emphasis meant that Wilbur Mills would be confronting Medicare legislation less than a year after he had successfully sponsored Kerr-Mills, an attempt to *prevent* direct federal intervention in medical care in favor of a means-tested, state-controlled system. Had Mills been persuaded of Medicare's value, his influence with the Ways and Means Committee, which he had chaired since 1957, was such that he likely would have been able to persuade the committee to report the bill favorably (Marmor, 2000). However, Kennedy found himself in the unenviable position of having some very high-priority legislation other than Medicare before Mills' committee, in particular his tax and trade legislation. This prevented him from being able, in 1961, to press Mills to report out the administration's King-Anderson health care bill (forerunner of the eventual Medicare Part A) to provide payments for hospital services to the elderly (Marmor, 2000; Weathers, 2004). On August 5, 1961, after nine days of House Ways and Means Committee hearings, generating 1,850 pages of testimony, the balance of committee votes remained against King-Anderson by a heavy margin. As King and the other Democratic leadership wished to avoid a negative vote on the record, the bill was not brought forward (David, 1985). As will be explored later, the parallels to the legislative situation in which Bill Clinton would find himself in 1993 are remarkable.

In early 1962, Kennedy issued a second message on health care to the Congress. Republicans, concerned that Medicare could become a critical issue in the November, 1962 mid-term elections, offered three proposals. Frank Bow (R-OH) introduced HR10755 providing for a yearly income tax credit of $125 to be used for purchasing a private policy. John Lindsay (R-NY) sponsored HR11253, which provided identical benefits to the King-Anderson bill, but added an optional cash increase to Social Security checks in lieu of benefits for those over age 65 who did not want the government's Medicare plan. The third bill, S2664, sponsored by Senator Jacob Javits (R-NY),

espoused a Social Security approach to financing with two plan options: a short-term, no-deductible policy or a simple cash payment so retirees could purchase a private pay policy on their own (David, 1985).

While Wilbur Cohen, HEW Secretary Abe Ribicoff, and others were working to develop a compromise bill, Under Secretary of HEW Ivan Nestingen, at the President's request, was working with some labor leaders and others on a grass-roots campaign to bring pressure to bear on the Congress. This effort was to culminate in an address by Kennedy before about 20,000 senior citizens and a television audience including all three major networks at Madison Square Garden on May 20, 1962. This rally was to be accompanied by 32 other rallies across the country scheduled for the same week with speakers ranging from Vice President Johnson to a number of Cabinet Secretaries and Wilbur Cohen. Kennedy's off-the-cuff remarks played well with the audience in the Garden, but fell flat on the television audience. The AMA responded with a counter-attack televised from the same podium in a completely empty Madison Square Garden. It was generally agreed among pro-Medicare supporters that the AMA had delivered the more effective speech to the public. Most, if not all, of the 32 other rallies were cancelled (David, 1985).

In the 1962 elections, Wilbur Mills faced his strongest opposition yet, largely the result of redistricting based on the 1960 Census. Additionally, he was under pressure from other House members not to report out a Medicare bill before the elections, which would force them to take a public stand in voting for or against the legislation. Mills sent word to the Kennedy Administration through Speaker of the House John McCormack urging the attachment of King-Anderson as a floor amendment to the welfare bill H.R. 10606, which the House was about to send to the Senate, circumventing the necessity of reporting the bill out of the Ways and Means Committee. The President did not look

favorably on this idea as it entailed the risk of a defeat if they were unable to secure enough floor votes to pass the measure (David, 1985).

In the Senate, Clinton Anderson was now working on a compromise amendment with Javits. With the help of Dirksen and Russell Long of Louisiana, Kerr managed to win a vote to table the amendment. Bobby Baker, who had been Lyndon Johnson's assistant and had continued as assistant to Majority Leader Mansfield after Johnson's election to the Vice-Presidency, was also instrumental in the defeat. According to David (1985), Baker's loyalty to Robert Kerr overshadowed his loyalty to his new boss Mansfield. To keep the White House calm, Baker managed to let Mansfield and O'Brien believe that the vote on the Javits-Anderson amendment would result in a tie, which the Vice-President could then break in favor of the amendment. Meanwhile, in a series of Machiavellian moves, Baker and Kerr were working to defeat the amendment, an effort that paid off on July 17 when the Senate voted to table the amendment by a vote of 52-48. David (1985) notes that the day after the defeat, "Bobby Baker took out a large personal loan in an Oklahoma bank owned in part by Robert Kerr" (p. 83). This effectively ended the 1962 attempt.

The AMA continued its full-court press against so-called "socialized medicine," spending about $2 million a year to ensure that Medicare would be defeated. Medicare advocates saw 1963 as a year to regroup and push for a bill in 1964. Meanwhile, public support for Medicare was waning. Gallup polls taken in the fall of 1962 and October of 1963 showed public attention focused more on foreign affairs such as Cuba and Berlin, not on Medicare (David, 1985). In the August Gallup Poll #662 (1962), only 45 out of 3,343 respondents named "Social Security, social services, welfare, old age, etc." as the Most Important Problem facing the country. By September of 1963 none of the 3,230 respondents reported these issues as the "most important problem" (The Gallup

Organization, 1963). In that poll, the overwhelming attention was on race relations and civil rights with 51.52% of respondents listing this as the most important problem facing the country. According to David (1985), a 1961 Gallup poll of doctors indicated that 81 percent opposed Medicare.

In February of 1963, Kennedy delivered a message to Congress on improving the nation's health, in which he stated "It is a tragic irony that medical science has kept millions of retired men and women alive to face illnesses they cannot afford" (Kennedy, 1963-1966, p. 141). Kennedy supported Forand's bill, but, history, in the form of an assassin, would intervene.

According to Wilbur Cohen's handwritten notes, on the morning of November 22, 1963, he was working with Henry Hall Wilson, White House Liaison to the House of Representatives, on a memorandum detailing a compromise to which both Wilbur Mills and Kennedy could agree. Wilson had a luncheon meeting and Cohen agreed to have the memorandum typed up over the lunch hour. Cohen wrote: "An hour or so later I heard a great deal of excitement in the hallway and when I went to discover the reason for it I learned President Kennedy had been assassinated. The memo was waiting for Wilson's return but he never came back to my office" (Cohen, n.d.).

Larry O'Brien (1974), Special Assistant to President Kennedy for Congressional Relations and Personnel, essentially corroborates Cohen's notes. He recalls that on Johnson's second night as President (November 23, 1963), Wilson told him of "an apparent breakthrough he'd made with Mills" (p. 186) on the morning of the assassination. O'Brien thought the matter of such importance that he directed Wilson to send a copy of the bill to the new president that same evening.

The assassination of John F. Kennedy brought Lyndon Baines Johnson to the presidency. Johnson leveraged the legacy of a very popular young President, who now

held martyr status, to create the liberal landslide of 1964. The Johnson administration deluged Congress with legislative proposals. The Great Society was off and running. Passage of civil rights legislation, voting rights legislation, and, in 1965, Medicare and Medicaid would be hallmarks of a fruitful domestic policy–all of it occurring in the shadow of a foreign policy nightmare–the war in Vietnam (David, 1985; Marmor, 2000; O'Brien, 1974; Weathers, 2004).

SUMMARIZING THE PATH'S DECISION POINTS UP TO LBJ

Initial efforts at a national health care program in the Progressive Era essentially ended with Woodrow Wilson's election in the early twentieth century (Goldfield, 1992). Franklin Delano Roosevelt had the option, and the apparent intention, of including national health care in the Social Security Act of 1935. Fearing that the entire Social Security Bill would be defeated if he overreached, and on the advice of his close advisors and the Council on Economic Security, Roosevelt elected not to tackle national health care. Had he done so *successfully*, the path would almost certainly have taken a decidedly different turn, eliminating the need for the employer-based system that followed and was bolstered by wage-price controls during World War II (Cohen & McComb, 1968; David, 1985; Marmor, 2000; Weathers, 2004).

President Truman took office on the death of FDR in 1945. In 1948, he was elected in his own right, a surprising result to many. He proposed a national health care system, flying in the face of stiff opposition. His efforts, though unsuccessful, laid the stage for future developments some 15 years later.

The rise of union power during the latter part of the depression, combined with wage-price controls in World War II, led organized labor to seek benefits for members, including health care, in lieu of the frozen wage increases. A Treasury Department decision that such benefits would be deductible to employers while not being reportable

as taxable income to the employees further reinforced the attractiveness of these employer-sponsored plans (Hacker, 1998). The unintended consequence of these policies, however, was to push the country farther away from a national system of health care. This also had the net effect of increasing the cost of care over time as labor pushed for increasing levels of benefits for its membership. Corporations utilized health and retirement plans as competitive strategies for recruiting as well. This conditioned American workers to expect comprehensive health care coverage as a part of their job compensation package, rather than from the government.

Very few corporations could afford to cover retirees as part of their health plans. Those that did were primarily the largest employers that operated under collective bargaining agreements, such as the automobile manufacturers. As most of the workforce was still not covered by union membership, many retired Americans found themselves without insurance. Numerous attempts, as outlined previously, were made to address this situation over the years from 1945 to 1963. Two major bills played roles in the path during this period. The first was the Social Security Amendments of 1950 (P.L. 734), which permitted the government to pay vendors directly for services rendered, primarily for the medically indigent. This arrangement set the stage for the passage ten years later of the Social Security Amendments of 1960 (P.L. 86-778) which included the Kerr-Mills amendment providing states with block grants-in-aid which states had to match with their own funds. These funds were then to be used to provide benefits to the medically indigent using a state-level means test; the states also determined the benefits that would be available to those who met the state's definition of medically indigent (David, 1985; Marmor, 2000). None of the proposals floated in the Congress over this period, whether initiated by the respective presidential administrations or by members of the House or Senate themselves, resembled anything remotely like comprehensive *national* health

insurance coverage. All were incremental approaches to covering “more,” but never “all” Americans. This was the path inherited by (and, in at least some respects, influenced by) Lyndon Baines Johnson who unexpectedly became president on November 22, 1963.

Chapter 5:
For Such a Time as This:
Case Study of Lyndon Baines Johnson's Administration and the Successful Passage of the Social Security Amendments of 1965

THE JOHNSON ADMINISTRATION – THE GREAT SOCIETY

In this section attention turns from the historical literature (i.e., secondary accounts) to original source documents, primarily from the LBJ Library. Observations and interpretations of original presidential and other archival documents are made in an effort to answer the first three orienting questions with respect to the Johnson Administration's eventual success at passing Medicare and Medicaid in 1965.

After giving at least cursory examination to an estimated 8,000 documents related to Medicare and Medicaid in the LBJ Library files, and more thoroughly examining approximately 4,000 pages of documents, several themes emerge. I will elaborate on these themes prior to the chronological case study details. In short, they are:

- President Johnson's keen understanding of the importance of words in framing the debate;
- Johnson's tendency to maintain control in the hands of a small, select group of seasoned political operatives and career policymaking professionals;
- Johnson's attention to the details of negotiations and policy consequences; and
- Johnson's highly developed sense of the political and legislative processes including the personal and local nature of politics, the importance of sharing the credit, and the importance of making each person feel as if his contribution was critical to the success of the effort.

First is Johnson's apparent understanding of the importance of words and how a debate is framed. For example, Johnson consistently stood against the idea of "socialized medicine," and in favor of "patient choice of physician." In a letter to a Dallas constituent in 1950, then-Senator Johnson expressed his "complete opposition to socialized medicine," which he had held "ever since his election to Congress thirteen years ago" (L. B. Johnson, 1950). He also understood, and apparently subscribed to, the idea that entitlement programs posed a potential moral hazard. In a phone conversation with Speaker of the House McCormack, Majority Leader Carl Albert, and Wilbur Cohen on March 23, 1965, Johnson asked Cohen for the particulars of the "[part B] over and above the King-Anderson, the supplementary you stole from Byrnes." This is the part of Medicare that pays for physician services. The moral hazard exists on at least two levels: what the physicians can charge the government and what the individual patient will receive in benefits. For some reason, Johnson first asked about the physician charges. The President asked whether the physician "charges what he wants to [under the program]." Cohen explained that the Secretary of HEW would contract with "someone like Blue Shield" to determine what the "usual, customary and reasonable charges" would be for any given service in a given location. This satisfied the President who then asked how the patient comes out financially. When Cohen explained the fifty dollar deductible and twenty percent co-payment requirement, Johnson responded "Well, that takes care of the hypochondriacs," clearly a part of how American society has come to construct health care provision ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965).

The second thing one observes in the LBJ files related to Medicare and Medicaid is the tight group of advisers and players in the events, particularly in the executive

branch. In addition to the President, probably the individual in his administration whose name comes up most frequently is Wilbur Cohen. Other important and frequent names include Larry O'Brien, Mike Manatos, Myer "Mike" Feldman, and Henry Hall Wilson, all congressional liaison and political advisers to the President, and to a lesser extent Jack Valenti, the President's Chief of Staff, and Bill Moyers, Special Assistant to the President. Notably, all were men. Among the legislators whose names are prominent in the files, the first is Wilbur Mills, Chairman of the House Ways and Means Committee. Other legislative names that figure prominently in the documents are Congressional leaders John McCormack and Carl Albert, as well as Senators Clinton Anderson, Russell Long, Mike Mansfield, Abraham Ribicoff, and Jacob Javits. (Ribicoff, it should be noted, had served as Secretary of Health, Education, and Welfare under President Kennedy prior to being elected to the Senate in 1962.)

A search of the telephone conversations database using the keyword "Medicare" reveals a total of 67 conversations on the topic, with 66 of these occurring sometime between November 22, 1963 and the time the bill was signed on July 31, 1965. Table 1 below illustrates the number of such conversations LBJ had with each of these persons. It should be noted that many of these conversations included other parties than the primary speaker on the call, but in most cases, these are people who have already been mentioned or appear on the list as a primary speaker. Only thirty names appear on the list as "primary speaker," and fifteen of them received only one such call. By far, the most calls (14) were between LBJ and Larry O'Brien who ran congressional relations for the President. Again, as previously noted, the recipients of these calls were all men. Women clearly did not play a large public role in the Johnson White House, at least not as far as the passage of Medicare and Medicaid were concerned.

Table 1: Number of Recorded Phone Calls LBJ had with each primary speaker:

Name	Number of calls
Larry O'Brien	14
Carl Albert	5
George Smathers	4
Walter Reuther, Myer Feldman, and Hubert Humphrey	3
Wilbur Mills, Mike Mansfield, Clinton Anderson, Hale Boggs, Russell Long, Albert Gore Sr., Bill Moyers, Wilbur Cohen, and Mike Monroney	2
Robert Byrd, Arthur "Tex" Goldschmidt, B. Everett Jordan, Alex Rose, Lee White, Carl Hayden, Earle Clements, Tom Hughes, Anthony Celebrezze, Frank "Topper" Thompson, George Meany, John McCormack, Edward Kennedy, Benjamin Spock, and Henry Hall Wilson	1

The third "theme" that stands out when reviewing the documents is the extraordinary command of detail that the President exhibited. Johnson not only understood the "big picture," but sought out and understood the finer points and nuances of both the legislation and the political environment. He is widely credited if not renowned for his political astuteness and stamina. The previously referenced phone call in which he asked Wilbur Cohen about the specifics of the bill being reported out of the committee included even his checking to be certain what was meant by "physician services" in the bill ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). In another example of his attention to detail, Johnson

responded with a handwritten note to a memo from Jack Valenti (who would later become President of the Academy of Motion Picture Arts and Sciences) on April 22, 1965. Valenti was passing along information from HEW Secretary Anthony Celebrezze. Celebrezze was concerned about press stirrings that Medicare would produce a drag on the economy (by then the Medicare bill had been reported out of the House Ways and Means Committee). LBJ wrote, "J – Please ask Ackley and Fowler to ask their friends to pipe down – L." Presumably, "Ackley and Fowler" were H. Gardner Ackley, Chairman of the Council of Economic Advisors, and Henry H. Fowler, Secretary of the Treasury. There is no mention of "Ackley and Fowler" in the memorandum from Valenti, but LBJ knew who was stirring up the pot and who could get them to "pipe down" (Valenti, 1965a).

The fourth "theme" in the documentation is the sense of the political and legislative process that Johnson had developed so keenly over the almost 30 years he had spent in Washington. Restructuring the House Ways and Means Committee with the cooperation of Speaker McCormack in the wake of the 1964 landslide election (David, 1985; L. B. Johnson, 1971; Marmor, 2000) is a prime example. Johnson clearly both understood and enjoyed the legislative/political process. When called by Speaker McCormack, House Majority Leader Albert, Ways and Means Committee Chairman Mills, and Undersecretary of Health, Education, and Welfare Wilbur Cohen on March 23, 1965, to be told that the bill was to be reported out of the Ways and Means Committee, Johnson can be heard to say: "For God's sakes, don't let dead cats stand on your porch. Mr. Rayburn [former Speaker Sam Rayburn] used to say that they stunk and they stunk and they stunk. When you get one [bill] out of that committee, you call that son of a bitch up before they can get their letters written" ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl

Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). Presumably the ‘they” he is referring to are the opponents of the legislation, including the American Medical Association in particular.

Johnson understood the personal nature of politics as well as the egos of the political players. Examples abound, but one related to health care legislation is his handling of several phone calls on September 24, 1964. The conference committee to resolve the Social Security amendments legislation between House and Senate had been meeting and had broken up badly earlier in the afternoon. This bill included the King-Anderson bill, which would later become Medicare Part A (hospital/surgical coverage). In the first two calls relevant to the meeting, Johnson plays the ego card. The first call, at 5:20 p.m. is to Senator George Smathers (D-FL). Smathers was of the impression that the conference report was “coming along,” but the President informed him he had heard otherwise. Smathers asked whether the President wants him to look into it and get back to him. The President replied in the affirmative “but don’t tell them I called, cause they’ll get jealous” ("Recording of Telephone Conversation between George Smathers and Lyndon Baines Johnson, September 24, 1964, 5:20 PM, Citation #5673," 1964).

Less than ten minutes after hanging up with Smathers, Johnson was on the phone with Senator Russell Long (D-LA). The President asked Long for a report on the conference committee and Long delivered a much more pessimistic (and, apparently accurate) report. The discussion proceeded about the positions of Wilbur Mills and Harry Byrd (a strong opponent of the legislation), as well as Long’s recommended parliamentary tactics for a vote in the House on Medicare with the view to forcing Congressmen on the record with their votes. Putting his fellow members on record as favoring or opposing Medicare is clearly an area where Mills was getting pressure to avoid bringing the matter to the floor for a vote, pressure which Mills was only too happy

to oblige. Near the end of the conversation, again, the President is heard to say to Long that he will “talk to Clint [Anderson] about it, but you forget I called so they won’t get jealous about it” ("Recording of Telephone Conversation between Russell Long and Lyndon Baines Johnson, September 24, 1964, 5:30 PM, Citation #5677," 1964). The implication, in both instances, is that the recipient of the instruction is in some sort of special position or relationship with the President which would make other members jealous. Before the evening was gone, he also spoke with Rep. Hale Boggs (D-LA) and Senator Anderson (D-NM). He understood that maintaining contact was part of maintaining relationships, and no one was more astute at the relational nature of politics than Johnson.

THE 1964 EFFORT

Lyndon Baines Johnson was sworn in as the 36th President of the United States aboard Air Force One at Love Field in Dallas shortly after the assassination of John F. Kennedy. Along with the many perquisites and burdens of the Oval Office, Johnson inherited the legislative agenda of the martyred President. Ever one to capitalize on whatever advantage he could find, Johnson held up the Kennedy legacy as his trust and vowed to enact the legislative agenda of Jack Kennedy (L. B. Johnson, 1971; Kearns, 1976; O'Brien, 1974).

On January 8, 1964, just seven weeks after the assassination, Johnson delivered his first State of the Union Address to a Joint Session of Congress. In the brief address, he called on the Congress to work together to enact bold initiatives in education, housing, poverty, hospital (but not full medical) care for the aged, hospital construction, tax cutting legislation and a host of other initiatives. He declared his faith that it could be “done by this summer” (Office of the White House Press Secretary, 1964). Johnson (1971) would later recall feeling that his administration had a very short window in which

to act, particularly given that the next presidential election was less than a year away when he took office.

Just eight days after the State of the Union address, Sen. Jacob Javits (D-NY) introduced the Health Care Insurance Act of 1964 in the Senate. The first prong of Javits' two-pronged approach, based on the report of the Flemming Commission,[4] would have provided "45 days of hospital care for all persons 65 years of age or over without deductible or option, up to 180 days of skilled nursing care, and up to 200 days of home care following treatment in a hospital" (Javits, 1964a, p. 1). This would be provided by an increase in the Social Security tax of one-quarter of one percent of payroll each on employers and employees. The second prong would provide a national private insurance program covering physician and non-institutional care to be offered on a non-profit, tax-free, optional basis with private insurers allowed to volunteer to offer the plans. There was no assurance that private companies would participate. Given the optional nature of the coverage, it was unlikely that insurers would be willing to offer such a plan due to the risk of adverse selection, i.e., only those who could not otherwise either qualify for or afford other coverage would be prone to enroll in the government-approved basic plan (Javits, 1964). Javits outlined his bill (S. 2431) in a one-page memorandum to the President (Javits, 1964b).

On the same day, Larry O'Brien (1964b) sent a memorandum to the President outlining his recent conversations with Wilbur Mills. O'Brien stated that Mills had not committed to either sponsor or support a Medicare bill, which O'Brien saw as critical in both cases. In the first of several bullet points outlining O'Brien's understanding of the

[4] The Flemming Commission was the popular name for the National Committee on Health Care for the Aged, chaired by Arthur S. Flemming, then-president of the University of Oregon. Flemming had previously served as Secretary of Health, Education, and Welfare under President Eisenhower. The 12-member commission formed in 1962, at least partially at the urging of Senator Javits, was to provide an independent review of the issues surrounding health care for the elderly.

"principal respects in which [Mills] would alter King-Anderson," a critical piece in the path-dependent journey is outlined. Here O'Brien relays to the President that Mills favors the use of the Blue Cross plans—founded and owned by the hospitals themselves—to administer the hospital insurance program, as opposed to letting commercial insurance companies have part of the administrative piece.[5] O'Brien sees this as "entirely agreeable," fully supportable by labor, and of such importance to Mills that meetings were being held the same day as the O'Brien memo to begin negotiations with Blue Cross toward administering the hospital program (O'Brien, 1964b). Blue Cross had been started by hospitals themselves (who continued to own the plans) in response to the Great Depression. Blue Cross was an effort to see that hospitals continued to receive some sort of payment even during the economic crisis. (Blue Shield, which is not mentioned in the O'Brien memo, was the physician-owned counterpart to Blue Cross.)

In a subsequent memo dated May 11, 1964, and outlining the discussions in Executive Session of the Ways and Means Committee, O'Brien (1964c) stated that Mills was then insisting that private insurers in addition to Blue Cross be permitted to bid on contracts, on a low-bid basis, for administration of the hospital benefits under King-Anderson. This represents an about face from Mills' January position as outlined to the President by O'Brien (1964a), but only to the extent that it would have permitted a broader number of private for-profit insurers to bid on the administrative contracts.

Why is this a critical point in the path-dependent nature of federal health care policy? Think ahead to today's Medicare Part C Advantage plans—private insurers offer coverage to the elderly and the federal government pays the premiums. With Part C plans, enrollees have the right to choose an approved plan administrator to pay the benefits rather than have them paid directly by the government to the provider (regular

[5] Asking the hospital-owned insurance plan to administer the government-proposed hospital coverage seems to pose a significant conflict of interest problem.

Medicare). These plans sometimes offer features and benefits that may differ from the regular Medicare benefits, and these are sometimes attractive to seniors based on their individual perceived needs for certain benefits. The Medicare Part D Prescription Drug plans are also administered by private insurers. This differs from Medicaid, in which states pay physicians either directly or through some managed care system. This idea of providing government benefits through private for-profit insurance companies has its roots in the philosophies of Wilbur Mills as outlined in the O'Brien (1964) memorandum.

Larry O'Brien was a holdover from the Kennedy administration. He had been a key operative in all of Kennedy's campaigns. He was an astute politician and very detail-oriented. Evidence of this can be found in another memo (O'Brien, 1963) to the President on December 5, 1963, only days after Kennedy's funeral. In this memo, O'Brien expressed his concern that if HEW Secretary Celebrezze spoke to the press about matters of importance to HEW after his meeting with the President and failed to mention Medicare, it could harm efforts on Capitol Hill. O'Brien does not elaborate as to why this would be harmful. One could surmise that it would signal a lack of full support for Medicare from at least some corners of the administration.

In July, Wilbur Cohen was busy providing cost estimates to his boss HEW Secretary Celebrezze over the various proposals for amending Social Security in both House and Senate. These proposals included increases in cash benefits, adoption of the King-Anderson hospital coverages, and changes required in the Social Security payroll tax rates (Cohen, 1964a).

Later that same month, Sen. Ribicoff sent a letter to the President expressing concern that passage of the five percent increase in benefits being proposed by Mills, and against which legislators would be reluctant to vote, would result in an increase in the payroll tax beyond the point at which Medicare could be added later. Ribicoff proposed

the “Free Choice Health Plan,” which would give pensioners the option at age 65 of taking the increased cash benefit or hospital insurance instead (Ribicoff, 1964b). We know that the President saw Ribicoff’s letter: A handwritten note transmitting the Ribicoff letter from Jack Valenti, his Chief of Staff, to the President contains a notation in the President’s hand telling Valenti to pass the letter to Larry O’Brien (Valenti, 1964). This proposal received considerable attention. On August 11, Ribicoff sent a letter and an outline of his “Free Choice Health Plan” proposal to Clinton Anderson, suggesting that it be held in reserve as a backup plan in the event that the original King-Anderson legislation did not pass (Ribicoff, 1964a). Clearly, Ribicoff was very concerned that Mills’ move to increase Social Security cash benefits was going to preclude adding medical care at a later date. On the same day, he sent a copy to the President.

On August 14, Larry O’Brien and his deputy Mike Manatos met with Senators Mike Mansfield (D-MT), Hubert Humphrey (D-MN), Clinton Anderson (D-NM), and Abe Ribicoff (D-CT) to discuss whether King-Anderson could, or even should, be passed and whether the Ribicoff plan should be offered in its place (Manatos, 1964a). According to Manatos’ memorandum summarizing the meeting, the general consensus was that passage of the cash benefit increase alone would effectively shut out any future attempt to add medical care for the aged through the Social Security system. The attendees further agreed that the Ribicoff plan was the only option, despite repeated and emphatic statements by O’Brien that King-Anderson had the “four-square” support of the Administration. Anderson, with the concurrence of the others, felt that Ribicoff “[made] political sense and offers an attractive campaign issue – it’s voluntary, it is elective and it is attractive.” The four senators also agreed that only the President would have a chance of persuading Wilbur Mills to accept Senate action. Finally, the group agreed that if Mills failed to concur, they should let the entire package die as passage of the cash benefit,

again, would shut out any future attempt at medical care legislation. On this last point, O'Brien recalled that Anderson expressed that sentiment, but that it had not received the concurrence of the entire group, and he reported it as such in his memo to the President transmitting the Manatos memo (O'Brien, 1964a).

In early August 1964, a meeting was scheduled at the White House between members of the National Medical Association, a group of "Negro physicians," and the President. Horace Busby's (1964) memo to the President stated the following: "This organization of Negro physicians is strongly in support of the Administration's hospital care for the aged proposals. Lee White, Louie Martin, et al, urge that Medicare – not Civil Rights – be the focus of conversation and discussion" [Emphasis in original]. Busby then went on to outline talking points for the President's consideration. It is not clear from the records whether the President followed Busby's advice for the meeting. The memo does, however, illustrate the sense of importance – perhaps even urgency – that the effort had taken on.

The White House Central Files pertinent to Medicare are filled with letters and telegrams from around the nation both supporting and denouncing the program. As one might expect, most of the letters from elderly persons supported at least some form of medical care for the aged. Most letters from physicians and their societies denounced the program, though a large number espoused the idea of a limited program for the "few" elderly who could not afford to cover their own medical expenses. On January 22, UPI reported on the testimony of Joe Belden, a Dallas public opinion pollster appearing before a committee (it is not clear which one) "at the request of the Texas Medical Association." Belden claimed to have polled 1,666 Texans, "most of them 65 or older." Belden stated his three primary conclusions that detracted from the need for medical insurance for the aged:

- Income alone is not a realistic measurement of the aged's financial condition.
- Almost half of all aged Texans (46 percent) appear to have health insurance, sufficient savings, or sufficient income, singly or in combination, to take care of medical needs.
- In addition to that half, 18 percent more said their children can help them with medical expenses (United Press International, 1964).

This and similar sentiments are echoed widely throughout the letters from physicians and their leaders. Some elderly individuals also took time to write the President to express the same sentiments.

In the case of public positions as polarized as those of the AMA (organizationally opposed) and the elderly (generally favorable), it is useful to consider counterexamples. First, with respect to elderly persons, one letter stands out as a counterexample. A self-described widow whose ancestors had come to America in 1637, Vinnie Clark (Mrs. Nicholas) Molitor (1964), wrote to the President on letterhead from The Park Manor Hotel in San Diego on January 8, 1964. Mrs. Molitor stated that she had no descendants and was opposed to Medicare, favoring instead the idea that local communities had the capacity and should be permitted to care for their own elderly poor.

On the physician side of the ledger, perhaps the most notable counterexample comes from Dr. Caldwell B. Esselstyn (1963) of Claverack, N.Y., writing as chairman of the Physicians Committee for Health Care for the Aged Through Social Security. The letter recalls a meeting of the group with then Vice-President Johnson and President Kennedy in March of 1962 and pledges continued support "as doctors of the concept of hospital insurance for the aged through social security [sic]." Perhaps as notable as the letter is the roster on the side of the letterhead, presumably of committee members. Among the 31 physicians listed, only one is from the deep South, a member from Nashville, Tennessee. David (1985), reporting on an interview she had with Wilbur Cohen, describes Esselstyn as "physician to Lou Gehrig and Eleanor Roosevelt, whose

Rip Van Winkle Clinic in New York was forced to close by the AMA because of Esselstyn's 'independent politics'" (p. 58).

On September 2, 1964, by a vote of 49-44, the Senate passed its bill attaching the Gore amendment (King-Anderson) to the House version (O'Brien, 1964d). The bill would now move to the conference committee. By this point, the President was locked in election battle for the presidency with Barry Goldwater, the Republican nominee, who voted against health care. In a rare glimpse into the political soul of Special Assistant to the President Bill Moyers, a memo from Moyers to the President on the same day reported that he had called Ken O'Donnell and Wayne Philips at the Committee to Re-Elect the President to suggest that they "'pull out all the stops' among organizations of older Americans…over Goldwater's vote against the health care plan." Moyers went on to say that he did not think the President should take on Goldwater himself over the vote but that "this is a great opportunity for us to beat him to death among these older people if we just play it right" (Moyers, 1964b).

Friends of the administration were working the grassroots side to build support for the Gore-Anderson amended bill. Nelson Cruikshank, Director of the Social Security Department of the AFL-CIO, joined forces with social welfare consultant and LBJ friend Elizabeth "Wicky" Wickenden to send a telegram to approximately 50 national social welfare, religious, and professional organizations urging them to call, write, and send telegrams to their congressmen and senators to press for passage of "social security hospital insurance before congress adjourns" (Cruikshank, 1964).

Marmor (2000) provides a concise and cogent explanation of the 1964 effort. What is striking in his account is how near King-Anderson came to passage. In fact, it was attached as an amendment to the Senate version of the Social Security Bill that had already passed the House. It had failed to be reported out as part of the House bill largely

due to the fact that, in spite of increasing numbers of pro-Medicare congressmen on the committee, the bill still lacked majority support on Ways and Means. By passing it through the Senate, the issue would have to be addressed in the conference committee. President Johnson, as both a former Congressman and former Majority Leader of the Senate, knew all too well the ways that bills could change in conference. Wilbur Mills was determined that Medicare would not pass in conference, which would have placed it beyond the control of his Committee on Ways and Means.

Previously, I outlined phone calls between the President and Sens. Smathers (D-FL) and Long (D-LA) regarding the breakdown of the conference committee over the King-Anderson bill on September 24, 1964. On that same date, shortly after hanging up with Russell Long, the President spoke with Rep. Hale Boggs (D-LA), who represented the House in the conference committee. Boggs essentially confirmed Long's account of the meeting, giving a pessimistic outlook and focusing on Wilbur Mills' parliamentary moves. Boggs recommended that if Medicare is not included, no bill should be passed at all, since he felt that giving the increase in cash benefits without the King-Anderson Medicare provisions would mean that they would never get Medicare ("Recording of Telephone Conversation between Hale Boggs and Lyndon Baines Johnson, September 24, 1964, 5:53 PM, Citation #5682," 1964).

Later that same evening, Johnson called Senator Clinton Anderson (D-NM), co-sponsor of the King-Anderson bill. Anderson characterized the day's conference committee meeting as "an awful bad day." He complained that "Wilbur [Mills] just didn't stand up to what he talked about at all." Johnson told Anderson a somewhat crude story to illustrate how he felt that "it just isn't my day." In doing so, he aligned himself with Anderson's feelings. The President congratulated Anderson on getting the foreign aid bill agreed to in the committee. When the President asked how he thought they should

proceed, Anderson responded that they should do nothing since the bill would not pass with the Medicare provisions. He essentially espoused letting it drop in favor of “do[ing] it better next time around” ("Recording of Telephone Conversation between Clinton Anderson and Lyndon Baines Johnson, September 24, 1964, 8:50 PM, Citation #5688," 1964). Just over a week later, on October 1, the conference committee adjourned without reaching any agreement. Medicare was apparently the only part of the bill considered (as opposed to the entire bill which included an increase in cash benefits). Senators Long, Smathers, Anderson, and Gore voted in favor of the Senate bill. Senator Byrd abstained explaining that he felt obligated to support the Senate’s position as a Senate conferee, but he personally opposed Medicare. Senators Williams and Carlson voted against the bill. Among conference representatives from the House, only Representatives Boggs and King voted to support the Senate bill. Voting against Medicare were Representatives Mills, Curtis, and Byrnes (Manatos, 1964c).

On October 4, 1964, the conference announced that it was deadlocked over the issues of both increased cash benefits for Social Security recipients and health care. Mills had succeeded in blocking the bill, relieving many congressmen who felt caught facing a choice between the elderly and the AMA. Mills had secured the block by promising conferees that he would bring Medicare up as the first order of business in 1965. This ended the 1964 effort (David, 1985; Marmor, 2000; Weathers, 2004). A timeline reviewing the major events of the 1964 effort appears in Figure 4 below.

Even after the bill was lost in 1964, efforts to persuade the public did not slow for even days. No more than four days after the failure of the conference committee to reach agreement, Bill Moyers (1964a) responded to a letter from Dr. Don W. Boston (1964) of Fort Worth. Boston’s letter of September 12 recalled his meeting Moyers as a patient in his office some years prior. Relying quite heavily on scriptural references, he states his

explicit wish early in the letter that "through your intercession and counsel, President Johnson will be influenced to make decisions in accord with established Scriptural principles." Apparently the main principle to which Dr. Boston refers is "the fact that God in the long ago established that a man must work or he would not eat." Moyers' response is eloquent in his assurance of the President's full confidence in the free enterprise system and his view, shared by Moyers, that the free enterprise system is not incompatible with "the participation of the Federal Government in programs designed to meet urgent national social and economical [sic] programs." Obviously, the 1964 failure did not slow the battle for Medicare.

If we accept the path-dependent nature of policy decisions, we can all be thankful that the Senate bill with the King-Anderson amendments did not pass in 1964. We can be equally, if not more thankful, that the Ribicoff proposal did not pass. Had either passed, Medicare would likely look much different today, if it even existed at all. King-Anderson addressed hospital costs for the aged only, with no provision for payment of non-institutional costs such as physician's fees. While it is true that this would not necessarily have precluded later passage of the optional Part B medical coverage, it would have meant another battle. Given that Congress had considered proposals for hospital-only coverage in one form or another since at least 1948, it is conceivable that it could have been at least that long before Part B would have been adopted.

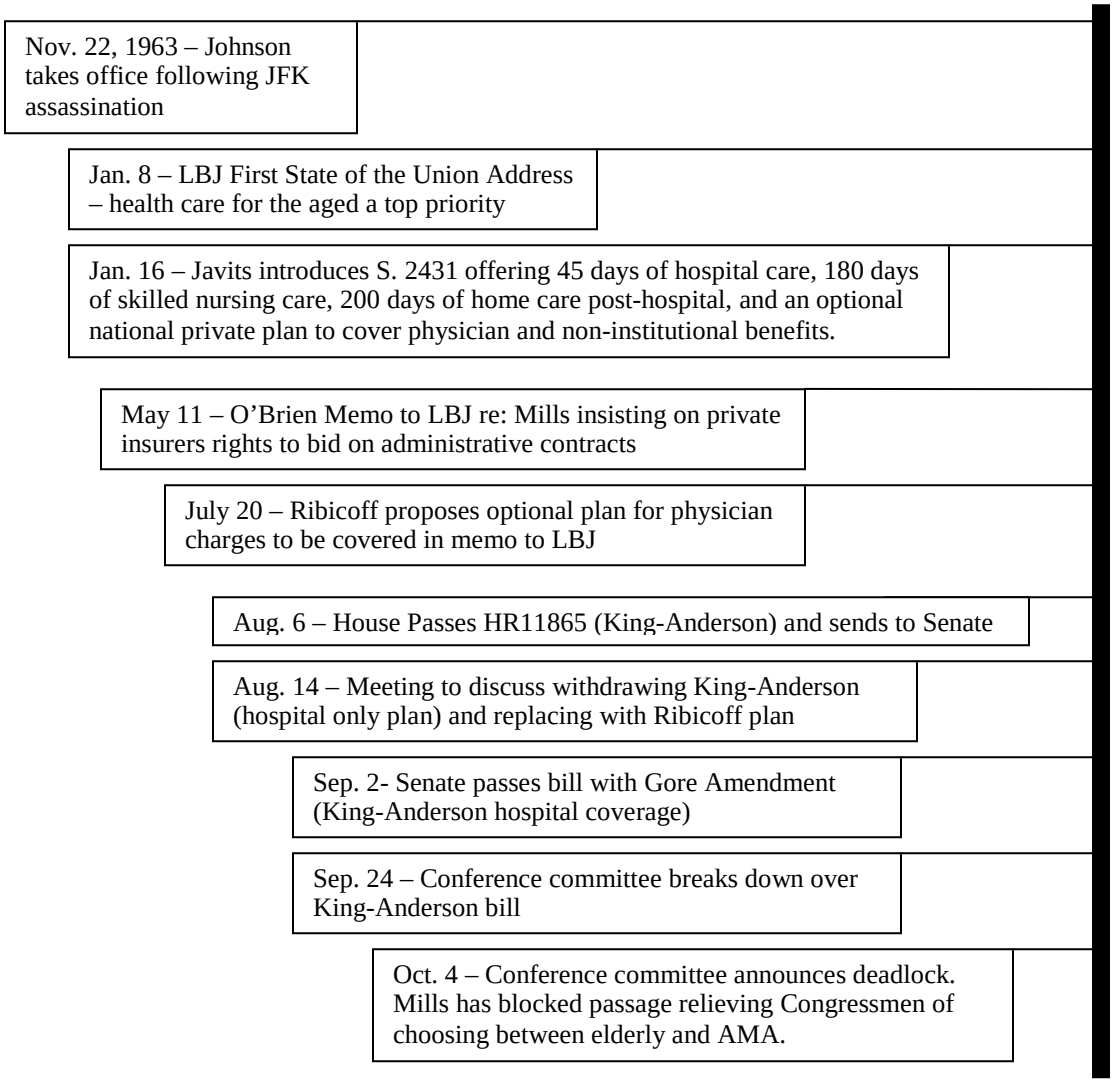


Figure 4: Timeline of 1964 Effort

The Ribicoff Health Choice Plan would have made any coverage optional—at age 65 pensioners could choose between a five percent Social Security cash benefit increase or optional hospital insurance. Seniors would not be permitted, however, to change their mind later. It is entirely likely that, had the Ribicoff plan passed, those who had coverage with their former employers or unions would have elected the higher cash benefit. As costs increased and employers sought to rid themselves of pensioner health benefits, these elders might have found themselves without coverage. Additionally, those who

enjoyed good health and could afford private-pay plans might also have opted out of the pool, resulting in a risk pool that subjected the plans to a much higher cost risk than blanket coverage would incur (i.e., adverse selection bias). In any event, the plans would have further fractured the coverage picture for the elderly rather than unifying it, as was the final result with the passage of the Social Security Amendments of 1965 that brought Medicare and Medicaid into existence.

PASSING MEDICARE AND MEDICAID – 1965

On November 3, 1964, Lyndon Baines Johnson was re-elected President of the United States by the largest margin in history. Johnson watched the election returns with family and friends at the Driskill Hotel in Austin, Texas. He saw the landslide results as "a mandate for action, and [he] meant to use it that way" (L. B. Johnson, 1971, p. 110).

On November 12, *The New York Times* (Hunter, 1964) reported on its front page that House Ways and Means Committee Chair Mills had said in a telephone interview from Arkansas that he was "ready to bring the long-stalled [health care for the aged] measure up in committee immediately after Congress convened in January if President Johnson asked him to" (p. 1). As a matter of law, legislation cannot be carried over from one Congress to another, which meant that a new bill would have to be introduced. Given the administration's strong position in the wake of the landslide election, it was unlikely that the new bill would contain as much compromise as the previous one (David, 1985). In fact, on November 25, 1964, HEW Secretary Celebrezze sent a memo to the President attaching Wilbur Cohen's summary of the redrafted bill. While the bill closely resembled the bill passed by the Senate earlier that year, including the Gore-Anderson amendments (which incorporated the King-Anderson hospital coverage as passed in the House), it also deleted seven controversial provisions that the Senate had added (including two amendments by Russell Long and one by the new Vice-President-Elect Hubert

Humphrey) and added some of the House-passed measures, including the cash benefit increases (Celebrezze, 1964).

The administration also did not waste any time counting votes. On December 8, Mike Manatos (1964b) sent a memo to Larry O'Brien indicating that they had lost two supporters of the Gore Amendment in the last election but picked up five. With the three who had missed the vote the last time, the projected new vote would be 55 to 45. Furthermore, Manatos speculated that persuading Senator Richard Russell would mean an even healthier margin of victory in the Senate. O'Brien forwarded the memo to the President the next day.

Work on the new bill was proceeding rapidly under Wilbur Cohen's direction. Outside interests continued to make their case for various changes they wanted in the bill. One in particular involved the Mayo Clinic. At the President's request, Cohen met with two representatives of the Mayo Clinic on December 23, 1964. These representatives sought a revision of the bill that would permit coverage for hospital inpatient and outpatient diagnostic services at the clinic, a revision Cohen felt was minor. In his memorandum to the President of the meeting, Cohen indicated they would include the necessary changes in the revised bill "which Senator Anderson and Congressman Cecil King wish to introduce in Congress on January 5" (Cohen, 1964b).

Senator Anderson had made an early request to Majority Leader Mike Mansfield to reserve the designation "S.1" (Senate Bill 1) for the Medicare bill. Congressman King also requested the "HR1" (House of Representatives Bill 1) designation for the bill in the House of Representatives (David, 1985; Marmor, 2000). The bills were introduced on January 6, 1965 ("MEDICARE MEASURE OFFERED IN SENATE," 1965). The President had made health care a priority in his State of the Union message on January 4 ("Transcript of the President's Message to Congress on the State of the Union," 1965).

Three days later, he delivered his Special Message to Congress on Health ("Johnson's Special Message to Congress Outlining Broad National Health Program," 1965).

By the end of January, Mills had started hearings in executive session on HR1. The fact that these hearings were held in executive session, and therefore excluded the press, is important. Wilbur Cohen was involved in most, if not all, of the sessions and reported back frequently. A memo from Cohen to Secretary Celebrezze on January 28 outlines two days of questions he and members of the HEW staff had received from committee members. He outlined his suspicions as to changes that Mills would want in the legislation, including a slightly higher tax rate than the administration proposed (1 percent versus 0.9%). At that point, Mills was skeptical of the idea of blanketing-in the present aged and paying those benefits out of general revenues, but Cohen felt Mills could be persuaded (Cohen, 1965b).

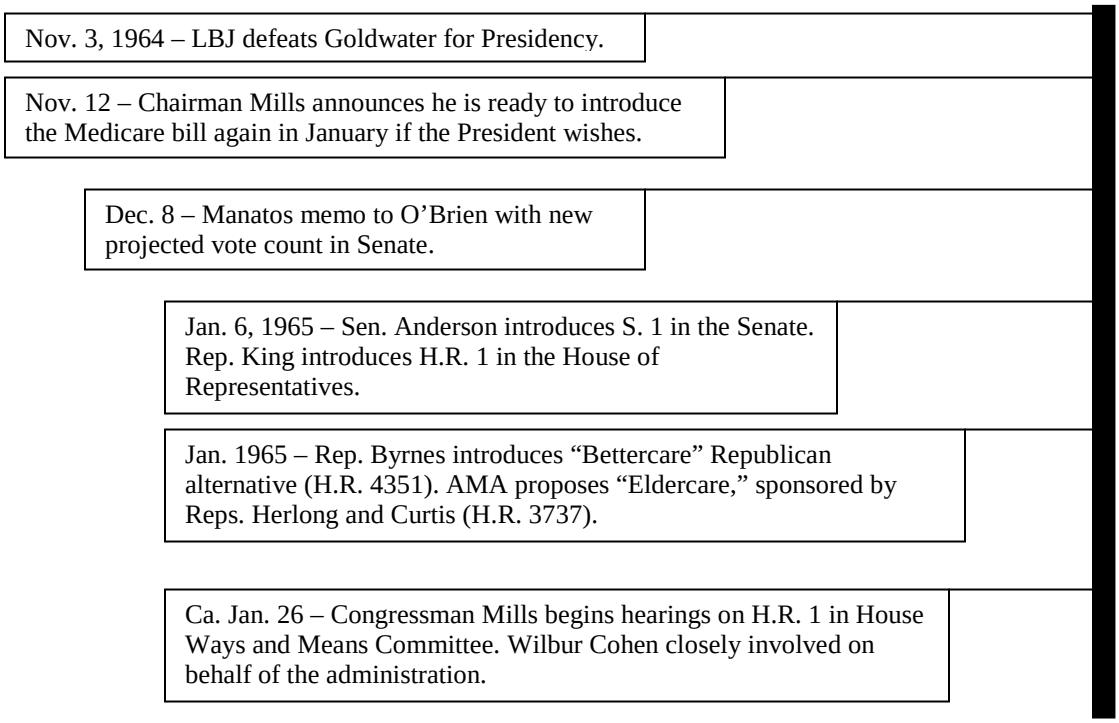


Figure 5: Timeline for November 3, 1964 to February 1, 1965

Competing Bills Offered by Republicans and the AMA

Congressman John W. Byrnes (R-WI) sponsored a bill that came to be known as "Bettercare." This voluntary plan included far more comprehensive benefits, including prescription drugs and fees for physician services, which the King-Anderson bill omitted. Premiums would be paid by those seniors who opted for the coverage; the federal government would subsidize premiums out of general revenues according to the senior's income level (David, 1985). In a memo to the President on January 29, 1965, Cohen outlined the major aspects of the Byrnes proposal, including several major problems. First, a substantial portion of the cost would be paid out of general revenues; second, many seniors of lower income or less stable cognition would not take the coverage; and third, it would pay charges and not costs (charges are higher than costs) as the King-Anderson bill provided. This last item would be considerably more expensive and subject the government to over-charging.

The Byrnes plan would have offered a comprehensive federal health plan to seniors where the King-Anderson plan offered a blend of federal assistance and private insurance. Perhaps most revealing is the last point in Cohen's memo. Cohen, an admitted incrementalist, frequently worked to pass an inferior bill on the notion that getting the principle in place would make it easier to get what one really wanted later. He accepted the moniker that one publication had given him of "salami slicer," that is one who took increasing numbers of very thin slices of salami ending eventually with the perfect sandwich (Cohen & McComb, 1968).[6] In his memo to the President, he makes the point that "if the principle utilized of the government <u>subsidizing</u> payments for health insurance protection made by individuals is extended to the entire population, the cost to the

[6] *The Harper Dictionary of Modern Thought* credits the coinage of the term "salami slicer" to Stalinist Matyas Rakosi in describing the manner in which the Hungarian Communist Party of the late 1940s dealt with their opposition (Bullock & Stallybrass, 1977).

general budget would be substantially greater" (emphasis in original) (Cohen, 1965m). Seemingly, Cohen's view of the eventual perfect sandwich would have included government subsidy of health insurance for the entire population, but he apparently felt this was beyond reach at the time. In his memoirs, Johnson himself wrote that this was the more desirable eventuality (L. B. Johnson, 1971).

Although Byrnes' "Bettercare" bill would eventually be incorporated into the Medicare bill, subsidizing premiums would not be as transparent (or need based) as Byrnes proposed. Seniors would be required to pay a premium for the Medicare Part B, subsidized out of general revenues, but these premiums would not vary by the income level of the senior and there would be no means-test required for the coverage. While one can understand that Mills' and Cohen's solution was better for seniors, the principle of subsidized premiums for the entire population was lost. The Byrnes plan might have provided a different path for later attempts at universal coverage.

It is ironic that, in the end, those most opposed to Medicare, including the powerful American Medical Association, shaped the more comprehensive nature of the final bill. The AMA criticized the administration's bill for being incomplete in its coverage (David, 1985), and recommended yet a third bill called "Eldercare," sponsored in the House by A. Sydney Herlong, Jr. (D-FL) and in the Senate by Leverett Saltonstall (R-MA). The AMA touted "Eldercare" as providing 100 percent coverage, but close examination revealed it provided significantly less than that. In fact, Eldercare was an expansion of Kerr-Mills, providing benefits contingent on each state adopting the program and providing matching funds. Twenty states had not adopted Kerr-Mills programs, presumably because of the matching funds required of them. Elders in those states would continue to be denied coverage unless their state legislature had a change of heart. Additionally, as with Kerr-Mills, the elderly would be subjected to the humiliation

of a welfare department means test in order to qualify for the state-sponsored benefits. Did Kerr-Mills technically *allow* states to cover all health services? It did, as would Eldercare had it passed. But in reality, very few seniors comparatively speaking would have been covered because most states would not offer comprehensive coverage and the others might stick with their decision not to participate at all (David, 1985; Marmor, 2000).

Cohen was excellent at keeping his bosses informed of what was going on. In a February 3, 1965 memo to Celebrezze, Cohen discussed the groups that had appeared before the Ways and Means Committee in executive session, including the Blue Cross Association, American Hospital Association, Kaiser Health Plan, Group Health Association, and state welfare officials. He outlined a number of problems that were coming to light. One such problem was raised by Edgar Kaiser and his Permanente plan. Kaiser wanted an amendment to the bill which would subsidize comprehensive group practice plans such as the Kaiser Permanente plan. Cohen's objection was that the amendment is based on the idea that certain plans should be subsidized from the resources of contributors covered under other plans. This would have interfered with the national pooling principle that formed the actuarial basis for the system. In other words, if plans with better risk selection were extended these subsidies, then only the poorer risks would remain in the national pool. Cohen felt that this adverse selection would undermine the plan's actuarial soundness (Cohen, 1965a). When Kaiser saw that the administration was not going to support his amendment, he asked for a meeting with the President. Instead, he was offered a meeting with Celebrezze and Cohen. The day after that February 17, 1965 meeting, Special Assistant to the President Douglass Cater reported to the President that Kaiser was still "very unhappy." Cater warned the President that Kaiser might bring it up during a meeting at the White House later that day (Cater,

1965). Kaiser's desired amendment ultimately failed, but it was not the last time Edgar Kaiser would try to influence national health policy. He would be considerably more successful not quite a decade later with Richard Nixon.

Up to this point, the administration had supported the King-Anderson bill, which would have covered hospital care but not physician services. The AMA had proposed "Eldercare" which would have offered comprehensive benefits, but only through the states in a funding extension of the Kerr-Mills Act, which required participants to pass a state-sponsored means test. As also noted, twenty states had yet to adopt Kerr-Mills due to the matching funds requirement. Finally, the Republican-sponsored Byrnes bill, known as "Bettercare," would have provided for a private insurance pool to cover physician fees on a non-profit basis, with premiums heavily subsidized by the federal government from general revenues. However, no insurers had expressed an interest in being part of the pool. And, then, Wilbur Mills spoke to Wilbur Cohen.

Absorbing the Competing Proposals – The Three Layer Cake

On March 2, a critical shift in the path occurred. That evening, in a two-page memorandum to the President, Cohen recounted that at about 3 p.m. that afternoon, after the Ways and Means Committee had completed its review of all the major pending health bills, "Mr. Mills turned to me and requested that we develop the details overnight of a proposal that will put together in one bill features of all three of the major bills pending before the Committee…" (Cohen, 1965p, p. 1). He went on to outline the three components, which were the major provisions of the administration's King-Anderson bill (Medicare Part A), a voluntary supplemental program of health benefits subsidized in part from general revenues and partly from premiums paid by those desiring the coverage (Medicare Part B), and an expanded Kerr-Mills program for the poor (Medicaid).

Cohen recognized the genius of Mills' plan. As he recounted it in the March 2 memo, the Byrnes bill would have required about $2 billion in general revenues to pay for the subsidies. Mills thought this figure ought to be between $400 million and $500 million a year. The difference is that the Byrnes plan did not require additional payroll taxes, instead paying for the benefits entirely from general revenues. More importantly, both Wilburs had become concerned that the Byrnes-introduced Republican plan would be used to attack the Administration's plan both in Congress and in the 1966 elections on the basis that the Republican plan included coverage for the major portion of the cost of physician fees, drugs, private duty nursing, and care in mental institutions, which the original Democratic plan did not (Cohen, 1965p).

Mills has been widely credited with figuring out that combining the three bills into one plan would make it very difficult for opponents of the King-Anderson bill to vote against the new bill (David, 1985; Marmor, 2000; Weathers, 2004). In this, and contemporaneous to the events, Wilbur Cohen concurred. "I feel reasonably sure that now after these several weeks of Committee sessions Mills now [sic] feels he has developed a combined package approach which is unassailable politically from any serious Republican attack" (Cohen, 1965p, p. 2). Cohen told the President that he and his staff would be working with Mills and the Ways and Means Committee the next day on this proposal.

Apparently, Cohen submitted his memo for the President through Larry O'Brien. Later the same day, O'Brien forwarded Cohen's memo and cover page to the President and attached a memo of his own indicating the "extreme importan[ce]" of the Cohen memo. O'Brien stated that he had spoken with Mills and that it was apparent that Mills was "definitely moving in this direction" (O'Brien, 1965b).

Cohen was true to his word about working out the details of the Mills-proposed plan, later to be referred to as the "three-layer cake," (See Figure 6). Medicare Part A (hospital coverage) was essentially the administration's initial proposal for hospital-only coverage. Medicare Part B, which covered physicians services, incorporated many of the features of the Republican-sponsored "Bettercare" bill introduced by Congressman Byrnes. Medicaid, the state-delivered, means-tested, and federally subsidized plan to cover the medically indigent, incorporated much of the philosophy of the AMA-endorsed "Eldercare" bill's approach. The next day, March 3, 1965, Kermit Gordon, Director of the Executive Office of the President Bureau of the Budget, sent a memo to the President returning the Cohen memo, which the President had handed him the night before. Gordon indicates in that memo that "As a service to Wilbur Mills, Cohen and his colleagues worked out last night the details of a plan embodying the Mills approach" (Gordon, 1965). Clearly the President had taken the Cohen memo, and accompanying cover memo from O'Brien, very seriously. Cohen, according to the Gordon (1965) memo, sent the detailed plan as worked out by HEW on March 3, 1965, directly to Gordon for his assessment of its effect on the budget.

As far as Cohen was concerned, Mills' request to combine provisions of the three major bills had been a surprise. It is possible that the idea had come to Mills suddenly. As late as February 25, Cohen had submitted a memo to the President outlining the objections to the AMA's Eldercare bill, and stating that the bill had not even been taken up in executive session by the Ways and Means Committee (Cohen, 1965l). On March 1, 1965, the day before Mills' conversation with Cohen, Bill Moyers returned the February 25 memo to Cohen with a note that the President had seen it and appreciated Cohen's sending it (Moyers, 1965b).

The White House apparently sensed the viability, if not the urgency, of the moment—the policy window had been flung wide open. Mills' conversation with Cohen occurred late on the afternoon of Tuesday, March 2 (Cohen, 1965p). By the next day, Cohen had worked out details of the plan and sent a copy to Kermit Gordon at the Bureau of the Budget (Gordon, 1965). Larry O'Brien had also spoken with Mills on March 2 (O'Brien, 1965b). In a memo reporting his Saturday, March 6 conversation with Mills, O'Brien told the President that Mills intended to complete the Committee work on it in the coming week and to have it ready to report out of Committee the week of March 15 (O'Brien, 1965c).

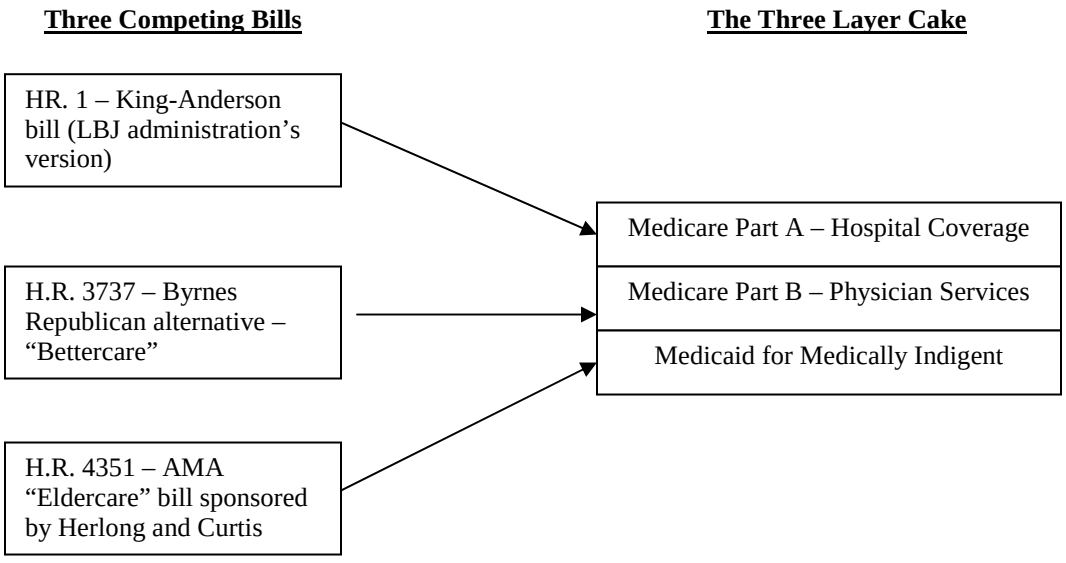


Figure 6: Wilbur Mills' "Three-Layer Cake"

Senator Ribicoff's Letter

On the Senate side, Abe Ribicoff was also recognizing that the King-Anderson form of Medicare was going to "disillusion millions of the nation's elderly" by not covering physician services (Ribicoff, 1965). Ribicoff sent his letter to the President on

March 3, the day after Mills' conversation with Cohen. It is not clear that Mills and Ribicoff had any direct communication on the matter. Ribicoff felt that many elderly believed that all of their medical bills would be covered instead of hospital charges only (and those only up to the prescribed limits of the bill). Ribicoff further expressed his concern that the effects of that disillusionment would reverberate in the 1966 elections when Republicans, who were pressing for a more complete plan (albeit one that would cover a relatively small number of people), would use Medicare to beat the Democrats.

That same day, Jack Valenti sent Ribicoff's letter to Wilbur Cohen and requested a memorandum from Cohen responding to Ribicoff's concerns. He wanted the President to see both Ribicoff's letter and Cohen's response (Valenti, 1965d). Cohen had spent the day with the Ways and Means Committee reviewing Mills' "three-layer cake" plan. On March 4, Cohen (1965d) sent a response to Valenti regarding Ribicoff's letter. The memo was transmitted to Mike Manatos at 11:40 on Friday, March 5, presumably so he would be aware of what was transpiring in the House in case it came up with Ribicoff. Manatos was the Senate liaison for the Administration, reporting directly to Larry O'Brien. In his memo, Cohen outlined the new Mills plan, concurring with Ribicoff that the original King-Anderson bill would have greatly disillusioned the elderly. Cohen's memo provides an extraordinary political analysis of how the Mills plan would be received:

> I think the AMA and the private insurance companies will likely be very much opposed to the bill, particularly this supplementary voluntary insurance system, which includes payments for physician's services. Nevertheless, I think practically all of the Republicans on the Ways and Means Committee will vote for the proposal, as well as most of the Republicans when the bill comes to the floor. However, the President may well be besieged by demands by the private insurance companies for dropping the new feature which Mills is adding. Politically, however, I think the Democrats on the Ways and Means Committee believe that the proposal now takes them off the hook from the very kind of criticism which Ribicoff points out would arise because of the limitations of the original King-Anderson bill. (p. 2)

This is remarkable in that the bill included most of the major provisions of the AMA's bill. What Cohen does not say in his memo is that the AMA's objection to the bill would come not because they did not approve of the benefits, but because their own version was tied to the Kerr-Mills financing arrangement which relied on state matching funds and a state-determined means test for seniors. Mills seized the idea, but eliminated the state-level requirements, making the benefits available to anyone receiving Medicare Part A. In essence, he was beating the AMA (and the Republicans) at their own game.

Valenti did indeed share the Ribicoff letter and Cohen's memo reacting to it with the President on March 6 (Valenti, 1965c). Johnson scrawled a note on Valenti's cover slip indicating that Valenti should "Ans[wer] Abe along the lines suggested by Wilbur." Apparently, Valenti asked Cohen to draft a response to the Ribicoff letter to be sent out over the President's signature, which Cohen provided to Valenti on March 8 (Cohen, 1965e). In the memo, Cohen told Valenti that Ribicoff had spoken with him over the intervening weekend, and that Cohen had the impression that Ribicoff might want to "improve" the bill when it got to the Senate Finance Committee. Cohen had added a sentence in the draft to try to encourage Ribicoff to speak with someone in the Administration before offering amendments to improve the bill.

The Ribicoff letter and the attendant responses surrounding it illustrate three things about the Johnson administration: 1) a very small, tightly-knit group was managing this legislative process; 2) the administration recognized opportunity and moved quickly on these opportunities; and 3) at every turn the political consequences were thoroughly examined. The first point is supported by the fact that the President consistently relied on Wilbur Cohen's advice and a small group of others with whom the President interacted directly. The second point is illustrated and supported by the speed

with which detailed memoranda were generated and delivered, often the same day as requested. Though this was an era before e-mail—an era rather of secretaries, typewriters, carbon paper, telephones, telexes, and couriers—responses could be expected within hours. For that matter, Cohen was able to draft the details of the "three-layer cake" literally overnight.

The third point in the preceding analysis, thoroughly examining political consequences, is perhaps best illustrated by the closure of the Ribicoff matter. As previously mentioned, Wilbur Cohen, at Jack Valenti's request, had drafted a response, typed on White House letterhead, from the President to Ribicoff. However, the spot where the President would have signed (and may well *have* signed), has been cut out of the letter (L. B. Johnson, 1965b). A carbon copy of the letter has a single strike through and the handwritten notation "not sent" (L. B. Johnson, 1965a). On March 9, Larry O'Brien (1965c) returned the original letter to the President with a cover memo asking Johnson to reconsider sending the letter to Ribicoff. His rationale boils down to the fact that Mills has announced that Ways and Means will report out a medical care bill about March 15 (less than a week later), Ribicoff would likely make political capital of the letter, and Senator Anderson may feel that the letter gives too much credit to Ribicoff without mentioning Anderson who "still must carry the ball in the Senate." On O'Brien's advice, the letter was not sent.

Moving Toward Final Passage

Things were heating up in the House Ways and Means Committee. Beginning March 11, 1965, Cohen provided daily memoranda to Larry O'Brien on the committee's progress. On that day, his one-page memo to O'Brien gave his update on the day's executive session of the committee, indicated several changes that would need to be made

to the "253 page bill," and that he would now not expect the bill to be on the floor of the House prior to the week of March 29 (Cohen, 1965f).

The Committee met for half a day on Friday, March 12, discussing only the tax policy included in the bill. This addressed tax deductibility of health insurance premiums (one-half of premium regardless of age) and limits on retirement income above which Social Security benefits would be taxed (Cohen, 1965g).

The Committee did not meet that weekend, but reconvened on Monday, March 15. According to Cohen (1965h), the discussion that day revolved around revising the Kerr-Mills program (Medicaid) and the Maternal and Child Health and Crippled Children programs. The Committee requested technical changes to the bill for their consideration. Cohen projected that Tuesday would be devoted to the increase in Social Security cash benefits and increase in federal grants for public assistance. He projected that the voluntary supplemental program would be raised in markup on Wednesday, and that the completely revised bill might be before the Committee by the end of that week.

On Tuesday, March 16, 1965, Cohen (1965i) continued to report the daily proceedings of the Committee to Larry O'Brien. Cohen made the following statement about the day's proceedings: "The major policy change was that the Chairman [Mills] instructed the draftsmen to exclude the Amish from social security taxes and benefits" (p. 1), presumably because of Amish religious objections. Bill Moyers had called Cohen earlier in the day to express the President's concern that radiologists and pathologists were to be excluded from the basic hospital program, and to request that Cohen tell Mills that the President wanted the bill changed with respect to this point. Radiologists' and pathologists' charges would have been covered under Part B (physician services). At the time, these specialties tended to be hospital employees who did not bill services directly but rather through hospital billing. Therefore, if they were not covered under Part A, they

would be forced to either end the employment relationship with the hospitals and become independent practitioners (thereby being able to bill under Part B), or their charges would not be covered in the plan. The radiologists and pathologists preferred to maintain the employment relationship and have those charges covered as hospital charges. Mills did not want the Social Security part (Part A) to cover *any* doctors' charges. Finally, Kermit Gordon, Director of the Bureau of the Budget, and Gardner Ackley, Chairman of the Council of Economic Advisors, were planning to meet with Mills the following day regarding effect of the contributions on the economy in 1966. Cohen agreed to Gordon's request that he attend that meeting.

On Wednesday, March 17, Cohen (1965j) met with Kermit Gordon, Gardner Ackley, HEW Actuary Robert Myers, and Mills to discuss the "fiscal drag" in 1966. Raising the payroll tax combined with the subsidies from general revenues for Medicare Part B premiums had the potential to remove too much capital from the economy. Mills asked Myers to prepare alternative financing rates that would reduce excess collections over disbursements below $1.27 billion for 1966. With respect to the radiologist-pathologist problem Moyers raised on behalf of the President (and reported in the previous day's memo to O'Brien) (Cohen, 1965i), Cohen spoke with Mills about it and Mills adamantly opposed the change. In the early afternoon, Cohen attended a meeting in Speaker McCormack's office with the Speaker and Majority Whip Hale Boggs to discuss the problem. The Speaker subsequently asked Mills to join the three of them where the Speaker tried to persuade Mills to make the change. Mills "want[ed] to be able to say on the House floor that physicians are not covered under the social security part" (p. 1). The Speaker was not successful at changing Mills' mind, but the Chairman did agree to put in the Committee report that radiologist and pathologist charges must be "reasonable."

The Speaker then called President Johnson and asked Cohen to explain the situation to the President. Cohen (1965j) reported that Mills would not stay in the room while they spoke with the President, who said that they should discuss it later and that "perhaps he [the President] should discuss it with Mills" (p. 2). Mills returned a few minutes later. Cohen reported that Mills was "'boiling mad'" because he had heard reports from some Democrats who had been at the White House the previous evening that the President was critical of Mills' efforts. Cohen reports that the group (McCormack, Boggs, and Cohen) tried to calm Mills, but he remained adamant about the requested change for radiologists and pathologists.

Why make so much of this radiologist/pathologist problem now? A memo from O'Brien (1965d) to the President on March 17, 1965, illustrates the importance of the point. In the memo, O'Brien explains the outcome of the meeting (attaching Cohen's memo for the President's review). He outlines possible alternatives that he had already explored with Cohen. In the final paragraph of the memo, he makes this revealing analysis: "Unfortunately with the exception of Al Ulman none of our Democratic Members are totally familiar with this bill and their total tendency is as you know to support Mills in all Committee matters [sic]." This illustrates the extraordinary power Chairman Mills held. O'Brien goes on to say that he thinks the only way to resolve it in the Committee would be for Johnson to speak directly with Mills, and O'Brien holds out no hope that even that would be successful based upon Cohen's judgment of the situation.

On March 23, 1965, the Committee, having finished its work, released a summary of its decisions to the press (U.S. House of Representatives Committee on Ways and Means, 1965). The cover of the release indicated that the bill would be filed on March 23, and the Committee Report would be filed on Monday, March 29. On the same day as the

release (March 23), the previously reported telephone call from Speaker McCormack to the President (and including Cohen, Majority Leader Carl Albert, and Chairman Mills) took place ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). This is the conversation where Johnson tells the Congressmen not to “let dead cats stand on your porch” and to “call that son of a bitch up before they can get their letters written.”

The Committee voted 17-8 along party lines to report the bill. Some Republican Committee members indicated that they might support the bill on the floor (J. D. Morris, Special to *The New York Times*,, 1965). On April 8, 1965, the House of Representatives passed the Social Security Amendments of 1965 by a vote of 263-153 (David, 1985). The next day, the President sent Speaker McCormack an exuberant note congratulating him on the bill’s passage. Among the strong sentiments expressed in the note are these words: “This measure alone would be sufficient to secure this Congress an honorable place in American history” (L. B. Johnson, 1965c).

On Larry O’Brien’s urging, the President also called a number of people to congratulate them on House passage of the bill. These included Speaker McCormack, Majority Leader Albert, Majority Whip Boggs, Chairman Mills, bill sponsor Congressman Cecil King (D-CA) and Congressman John Dingell (D-MI) who presided over the debate. Dingell’s father had co-authored the Wagner-Murray-Dingell bills during the late 1940s and early 1950s and the original Dingell-Forand Medicare bill introduced in 1958. O’Brien also suggested calling Aime Forand, former Representative from Rhode Island; the President was unable to reach Forand but left word that he had called (O'Brien, 1965a). This illustrates an earlier-stated theme of the analysis: President

Johnson understood the personal nature of politics and the importance of his personal touch in the process.

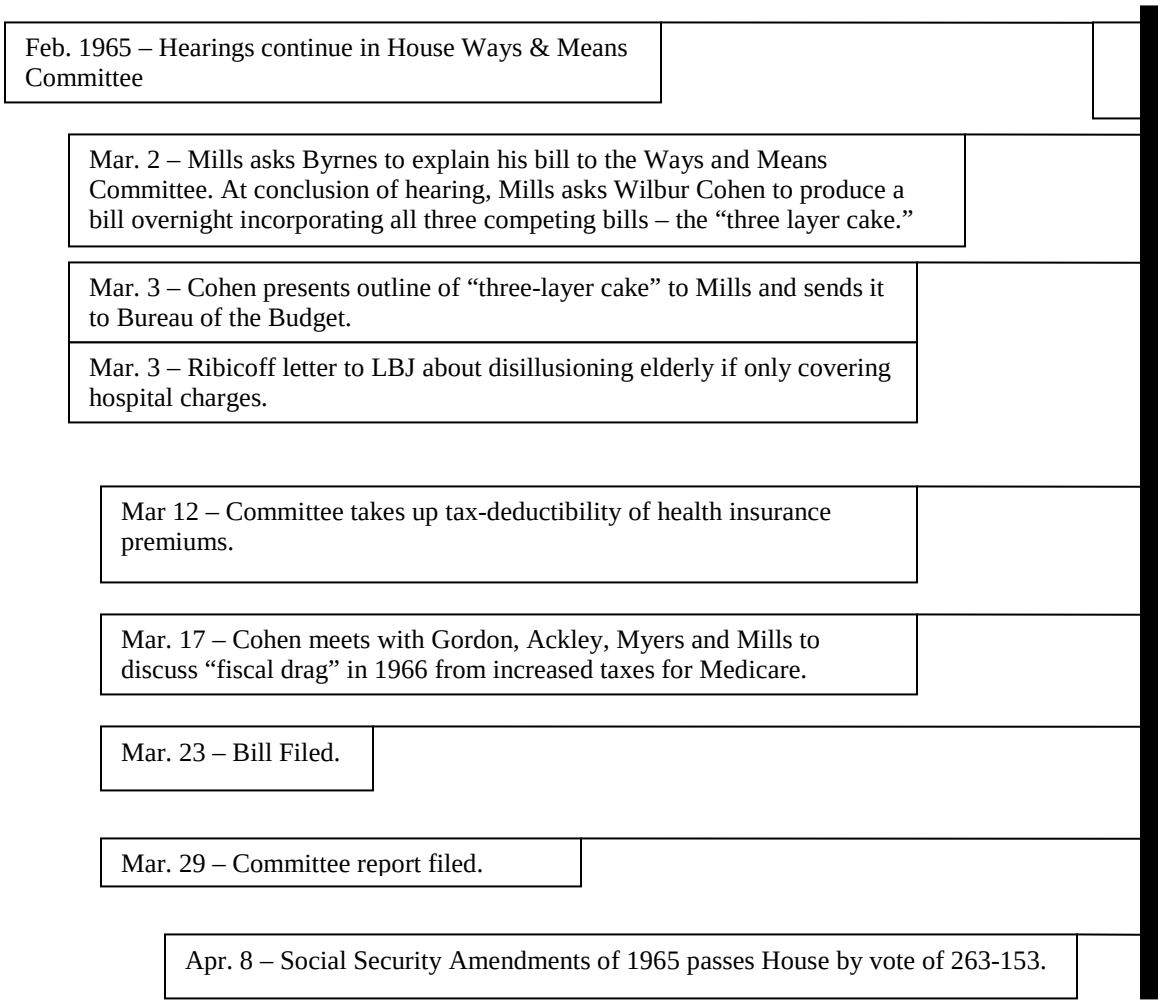


Figure 7: Timeline for February 1, 1965 to April 8, 1965

Much has also been made of the ways in which President Johnson rewarded his friends and punished his enemies. Attached to a memo in the files written on April 9, 1965, from Charles D. Roche, Deputy Chairman of the Democratic National Committee, to Special Assistant to the President Marvin Watson, is a list of "incumbents in the critical 1966 campaign" including how they voted on Medicare. Roche, apparently

speaking for the committee, says "We are recommending that appropriate steps be taken to reward those Members who have distinguished themselves with loyal support of Administration recommendations" (Roche, 1965). However, no presidential response to the memo was found in the files.

Desegregation and Medicare

Under the chairmanship of Harry Byrd (D-VA) the Senate Finance Committee was now to take up the House bill. On April 13, 1965, Byrd (1965) sent a letter to HEW Secretary Celebrezze. Attached was a letter from Mr. J. F. Ditzell, President of the Board of Trustees of the Winter Park Memorial Hospital in Winter Park, Florida (Ditzell, 1965). Ditzell raised the issue of whether hospitals who receive money either through Medicare or through Blue Cross payments for federal employees would be considered as "receiving federal monies," an idea that Ditzell finds "almost inconceivable." The letter itself does not elaborate on why this is an issue. The subsequent flurry of correspondence clarifies the issue.

Prior to Senator Byrd's letter to Celebrezze, White House Counsel Lee C. White had requested a memorandum from the Department of Justice as to whether and to what extent Title VI of the Civil Rights Act of 1964 would apply to Medicare. If so, this would mean that hospitals receiving Medicare payments would have to desegregate. Andy Biemiller of the AFL-CIO had raised the question. On April 6, 1965, Norbert Schlei sent the requested 11-page memorandum to White (Schlei, 1965). The essence of the memorandum was that the Department of Justice held the opinion that payments under the program constituted insurance payments on behalf of covered persons and were, therefore, not direct federal payments to the providers. In such a view, Title VI prohibiting discrimination in facilities receiving federal funds would not apply. Neither

would the Due Process clause of the Fifth Amendment to the U.S. Constitution apply in the view of the Department of Justice as expressed by Schlei.

Deputy Special Counsel to the President Clifford Alexander asked staff lawyer Steven R. Rivkin for his thoughts on the Schlei memorandum. Rivkin (1965) offered a number of methods by which the Administration might achieve desegregation of health care facilities under Medicare including rulemaking possibilities and constitutional theories. With respect to Schlei's 11-page memorandum, Rivkin based much of his response on a single paragraph from the memo.

In a memo to the President on April 26, 1965, Counsel White states that the Justice Department had concluded that Title VI would not apply to hospitals receiving funds through Medicare, but that "they could support a theory that the Title does apply if it is desirable to do so" (White, 1965, p. 1). White went on to outline the delicate dance ahead in both the Finance Committee and the full Senate over the issue. On the one hand, if Celebrezze tells Byrd that the Administration "cannot prevent discrimination by participating hospitals, the liberals will insist on an amendment making this clear" (p. 1). On the other hand, if they indicate that they do have the authority to prevent discrimination, that may signal some southern Senators prepared to support the bill to re-examine their position. Apparently, Celebrezze's initial reaction was to say that Title VI does not apply, but White was of the opinion "that the Secretary should be instructed to answer that it is applicable" (p. 2). Celebrezze was scheduled to testify two days later. White said that Celebrezze's testimony plus his formal response would prove helpful in any judicial test of the Administration's authority to prevent discrimination by indicating Congressional intent on the issue, presumably in a relatively low-key fashion. He recommended sending the reply from Celebrezze to Byrd on Tuesday and provided a

proposed draft of the letter (White, 1965). Moyers supported this idea and asked White to see to it that HEW followed that line (Moyers, 1965a).

By early May, Senator Russell Long (D-LA) was starting to become troublesome. He wanted to amend the Senate bill by combining the hospital care provision and physician services payments. He also wanted to eliminate the $3 per month premium for the Part B and put that cost on general revenue, which would create an estimated drag of an additional $400 to $500 million on the Treasury. His rationale for the first amendment was to be able to say to physicians that they would not have their income or practices severely affected by any attempt to provide the Medicare coverage to persons under age 65. His rationale for the second amendment was to save the elderly the premium. Wilbur Cohen told the Senator that it would be unlikely that anyone would ever want to offer Medicare to persons under age 65 since they could mostly get their own coverage through employer-sponsored plans (Cohen, 1965k).[7]

In what probably seemed fairly minor at the time, but is of certain interest today, Long also wanted to provide payments for drugs under Medicare. Cohen managed to persuade him that the financial costs would be excessive. Long still wanted to include at least antibiotics and other "major drugs" in the coverage provisions (Cohen, 1965k).

By late May, Long was still seen as problematic to the bill's passage. In a letter written May 28 to Jack Valenti, Elizabeth "Wicky" Wickenden, social welfare consultant, expressed her concerns:

> I am very worried about Senator Long's advocacy of a substitute medicare proposal. This is tactically divisive, administratively infeasible, and substantively regressive. He makes it sound like a liberalization but in actual fact it plays directly into the AMA-Republican position. Coming from the Democratic whip it is most confusing and I think the President should talk to Senator Long directly

[7] Clearly, this was a rare occasion where Cohen's foresight was limited, since there have been recent proposals to extend Medicare to the general public on at least a voluntary basis.

> before the Finance Committee acts. I understand this will be next Wednesday. (Wickenden, 1965)

Over the next six weeks, Long wandered in and out of the Finance Committee meetings several times a day to see how the votes were shaping up. On June 17, he brought his amendments up and said that the Administration had no problems with them. He called for an immediate vote and the two amendments—one combining Part A and Part B and the other eliminating the $3 per month premium for physician's services coverage—passed. However, Clinton Anderson had Senator Fulbright's (D-AR) proxy. Long claimed to have a more recent proxy of Fulbright's. Both were produced and the clerk said that Long's was more recent. The vote was 8-6. After the vote, Anderson asked to see the proxies. It turned out that Long's was in fact more recent, but pertained to an entirely different matter. When Fulbright returned, he and Anderson went to Long. Mike Mansfield also spoke to Long. Long simply said that there must have been a misunderstanding and agreed to a second vote (David, 1985).

Administration supporters, including Nelson Cruikshank and Andy Biemiller of the AFL-CIO, Wicky Wickenden, and Wilbur Cohen went into high gear to change votes on the committee (Cohen, 1965n). On June 23, Long's amendments were defeated by a vote of 10-7 (Valenti, 1965b). The next day, the Senate Finance Committee reported out the bill by a vote of 12-5 with 75 amendments to the House bill (Cohen, 1965o; David, 1985).

Russell Long was not yet finished. He was to be the floor manager for the bill. Anderson worried that Long would open the bill to other amendments on the floor. He wrote to the President on July 1 expressing his fear that the bill would be amended beyond the hope of reconciling it in conference (C. P. Anderson, 1965).

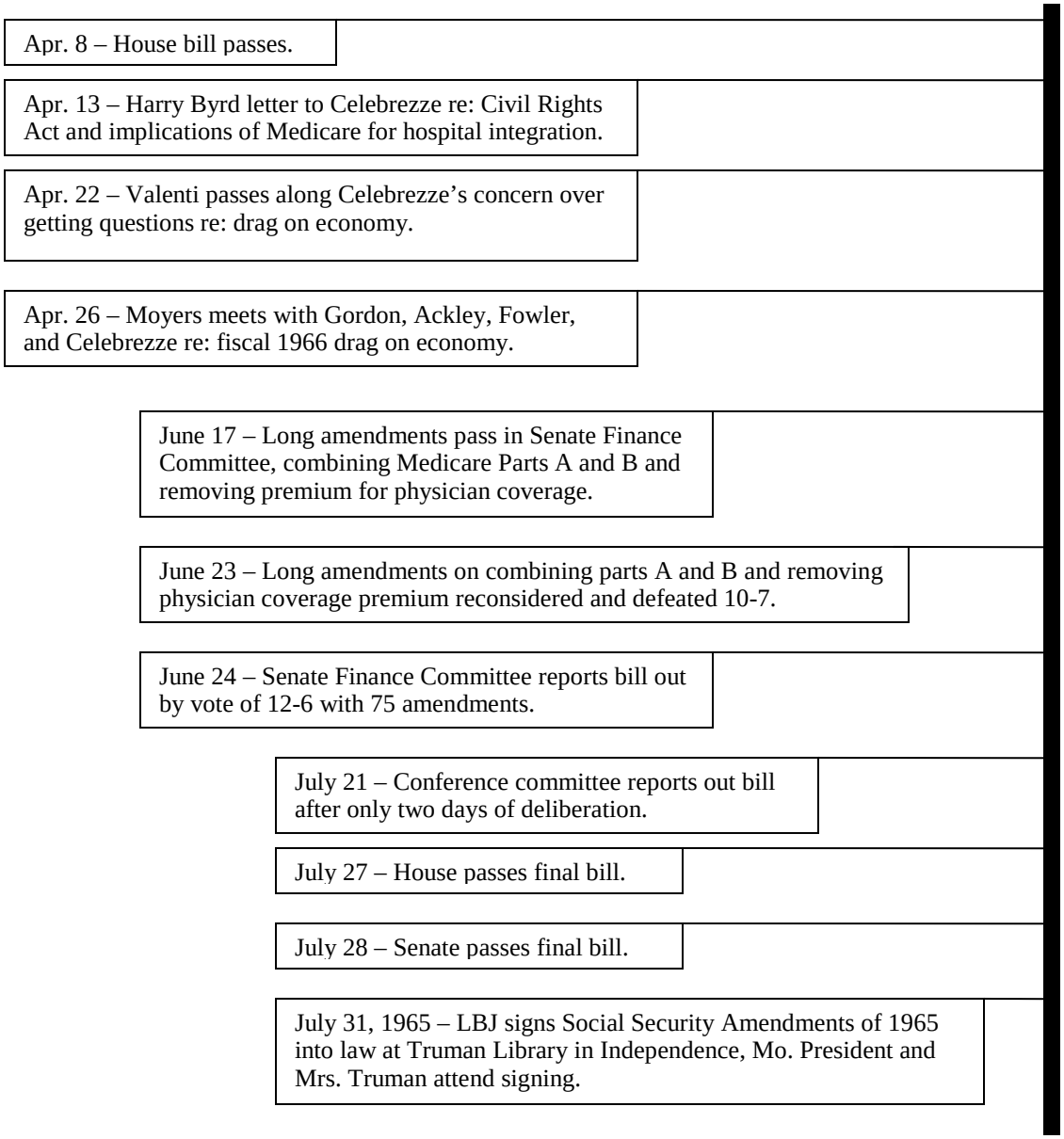


Figure 8: Timeline for April 8, 1965 to July 31, 1965

The Senate passed the bill on July 9, 1965 by a vote of 68-21. There were a total of 513 amendments; most were technical in nature. The conference committee began its work on July 19. It appeared for some time that Mills, Boggs, Long, and Smathers were actually trying to wreck the conference. However, on July 21, 1965, the conference committee reported out the final bill. On July 27, the House passed the bill by a vote of

307-116. The following day, the Senate passed the bill by a vote of 70-24 (David, 1985; Marmor, 2000).

All that remained was the President's signature. Wilbur Cohen had advised that signing it by July 31 would mean a payment of an extra $30 million to widows and orphans. Time was of the essence. The President wanted to have the signing ceremony at the Truman Presidential Library in Independence, Missouri, with the former President and Mrs. Truman in attendance. Cohen and Horace Busby were radically opposed to this idea on the grounds that it would draw parallels between the new act and Truman's objective, which was to provide medical coverage for the entire population regardless of age. This was seen as "socialized medicine" of the British form. Cohen and Busby feared that signing the bill at Independence would send the signal that the next step would be to enlarge Medicare to cover the entire population. They were further concerned that the signing might include "some distasteful remarks by President Truman himself about the medical profession" (Busby, 1965). By the time the bill passed, it was clear that the President intended to sign the bill at the Truman Library. On July 26, Cohen submitted a 13-page list of potential invitees (Cohen, 1965c). The bill, which ran to about 400 pages, had to be engrossed before the President could sign it. This was rushed through. On July 27, Johnson called former President Truman to tell him that he wanted to come to Independence for the bill signing. On July 30, 1965, President Johnson signed the Social Security Amendments of 1965 into law at the Truman Presidential Library in Independence Missouri. President Johnson later recalled that "It was a proud day for all of us, and President Truman said that no single honor ever paid him had touched him more deeply" (L. B. Johnson, 1971, p. 219). A timeline covering the period from passage of the House bill on April 8, 1965 to its signing on July 31, 1965 appears in Figure 8.

Though he did not take steps to extend Medicare to the entire population, President Johnson did consider Medicare a revolutionary step in that direction. In his 1971 memoirs, he said "I had the same sentiments about Medicare, whose overriding importance to me was that it foreshadowed a revolutionary change in our thinking about health care. We had begun, at long last, to recognize that good medical care is a right, not just a privilege" (L. B. Johnson, 1971, p. 220). But, 38 years after the publication of his memoirs, more than 46 million Americans still have no health insurance.

MEDICARE AND THE PRESS

In 1964-65, there were no national cable news networks, there was no public Internet, there were no 24-hour news channels, and conservative talking heads had not yet taken over the AM radio band. People largely relied on the three major television networks, radio, newspapers, and news magazines for their news. By the time of the Clinton Administration, this had all radically changed. I have previously made the case that we could use newspaper coverage as a reliable indicator of media attention that could be accurately compared across the two eras. I rely upon the approach of McCombs (2004, 2005) in this part of the endeavor.

A search of the ProQuest Historical Newspaper Databases for *The New York Times* and *The Los Angeles Times* for the dates November 4, 1964 (the day after the election) to July 28, 1965 (the day the final bill was passed by the Senate) and searching for the terms "health care" or "aged" and "medicare" anywhere in the article text revealed a total of 224 documents between the two newspapers that met the search criteria. Of these 224 articles, only 26 appeared on the front page of the paper (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009) .

The breakdown by newspaper shows 114 documents for *The New York Times* with 22 appearing on the front page (ProQuest Historical Newspapers The New York Times [1851-2005], 2009). *The Los Angeles Times* provided 110 articles over the period with only four appearing on the front page (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009).

Editorials comprised eleven documents in *The New York Times*. Of these, only two were negative towards Medicare. One was a more general editorial praising some of the President's success with Congress early in his first full term. The other eight supported passage of Medicare (ProQuest Historical Newspapers The New York Times [1851-2005], 2009).

Over the same period, *The Los Angeles Times* carried eleven editorials. Of these, four would be considered "cautionary" in nature, and the other seven clearly opposed passage. Most of the opposition was on the grounds of increased taxes to pay for the program or increased medical cost as a result of the elderly's demand for care increasing in light of government's agreement to pay for the care (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009). Notably, one of the editorials was a guest column by Barry Goldwater (1965) in which he referred to the impending passage of Medicare as "the biggest step into welfarism since the passage of the original Social Security Act" (p. A5).

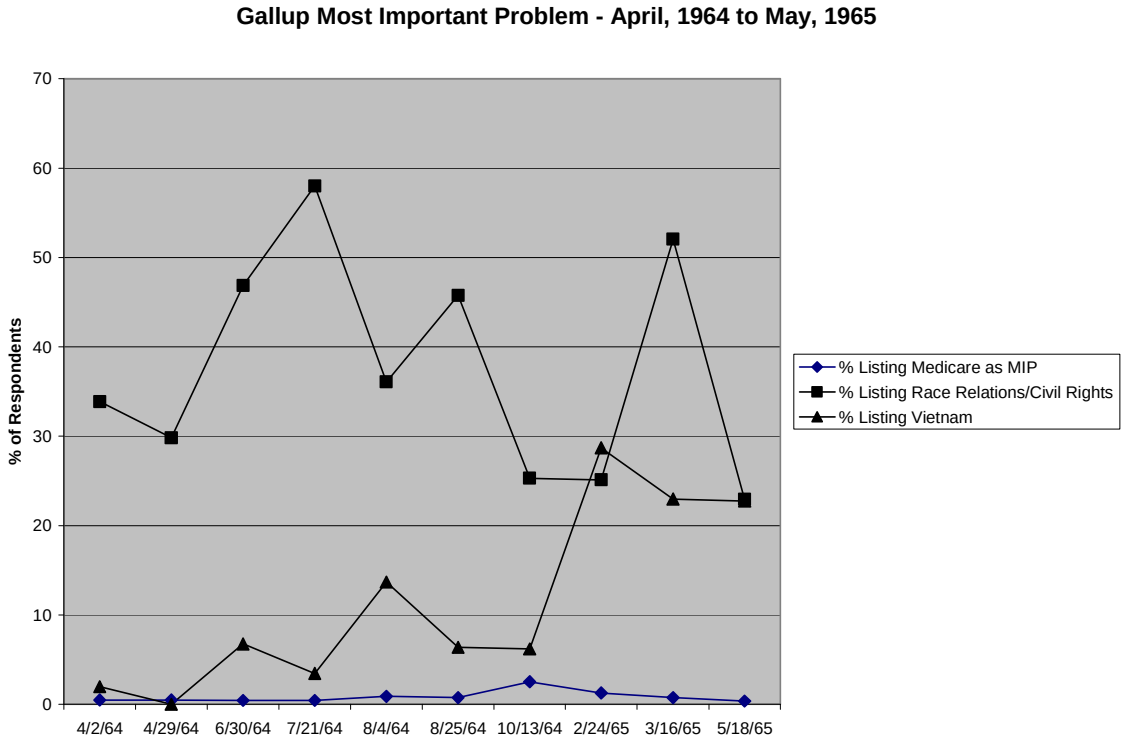
Clearly, Medicare was not subject to intense media scrutiny during the period under study. Rather, the media was focusing its attention on the escalating Vietnam War and civil rights pressures building inside the country. This would not prove to be the case nearly 30 years later when Clinton attempted to pass national health care reform.

MEDICARE AND THE GALLUP POLL'S MOST IMPORTANT PROBLEM QUESTION

While health care for the aged may have been a major focus of the administration, it was hardly the public's major focus. During this period, the public was focused much more intensely on issues such as race relations, civil rights, and Vietnam. Results of The Gallup Poll's Most Important Problem question illustrate this focus.

Several times a year since the 1930s, The Gallup Organization has asked large samples of the public this question: "What is the most important problem facing this country today?" For the period from April of 1964 to May of 1965, the sample sizes ranged from 3,493 (Poll #706, completed February 24, 1965) to 4,003 (Poll #697, completed August 25, 1964). The number of respondents listing "Social Security – aid to aged, Medicare" in those polls ranged from a low of 13 (Unnumbered Poll, completed May 18, 1965) to a high of 88 (Poll #699, completed October 13, 1964). The percent of respondents listing "Social Security – aid to aged, Medicare" in those polls ranged from .37 percent (Poll #689, completed April 29, 1964) to a peak of 2.51 percent (Poll #699, completed October 13, 1964; The Gallup Organization, 1964a, 1964b, 1964c, 1964d, 1964e, 1964f, 1964g, 1965a, 1965b, 1965c).

By comparison, over the same period and the same polls, percentages of respondents listing "race relations or civil rights" as the most important problem facing the country ranged from a low of 22.95 percent (Unnumbered Poll, completed May 18, 1965) to a high of 58.03 percent (Poll #695, completed July 21, 1964). The percentages of respondents listing "Vietnam" as the most important problem facing the country ranged from a low of 0 percent (Poll #689, completed April 29, 1964) to a high of 28.71 percent (Poll #706, completed February 24, 1965; The Gallup Organization, 1964a, 1964b, 1964c, 1964d, 1964e, 1964f, 1964g, 1965a, 1965b, 1965c). Figure 9 illustrates the pattern of all three responses over the period from April, 1964 to May, 1965.



Source: The Gallup Brain. The Gallup Organization. Retrieved July 11, 2008. Gallup Polls Nos. 688, 689, 694, 695, 696, 697, 699, 706, and 708 conducted between March 27, 1964 and March 16, 1965 and an unnumbered poll conducted between May 13, 1965 and May 18, 1965.

Figure 9: Gallup Poll Most Important Problem (MIP) Question – April 1964 to May 1965.

It is widely held that public opinion and mass political behavior rarely result in direct political action on the part of the government or the elites running the government. Rather, public opinion largely has the capacity to constrain the parameters within which decision-makers can operate (Dye, 2007; Key, 1966; Mazmanian & Sabatier, 1980; Rochon & Mazmanian, 1993). In the case of Medicare in both 1964 and 1965, the public simply was not focused on the problem. In line with theories on the effects of public opinion, we would not expect it to drive the issue, and since it was not on the public's

radar, neither did it constrain or restrict decision-makers' actions to any appreciable extent. This is not to suggest that perceived future political ramifications of decisions did not in fact constrain the decision-makers' parameters. Indeed, as previously explored, I find that the contemporaneous documentation at the time speaks often of the effects that certain decisions would have either directly on the next election in 1966, or at least on the potential positioning of the parties in that election. Concerns over how the opposition would use certain decisions to set the agenda are replete in the memoranda of the Administration participants. In fact, to a large extent, Wilbur Mills' "three-layer cake" can be attributed to these constraints. Mills wanted a bill that would be difficult for Republicans to vote against because a) their own proposals were included, and b) voting against the bill would negatively affect their positions at home in the next election cycle. In the "three-layer cake," he found his solution. While on the subject of public opinion and Medicare, it is worth noting that Oberlander (1995) found, in part, that public opinion post-1965 had played a weaker role than the theoretical models would suggest in terms of subsequent legislative changes to the program.

SUMMARY

By the time Lyndon Baines Johnson took the oath of office aboard Air Force One in Dallas, Texas, on November 22, 1963, Medicare in some form or other had been before the Congress for at least 15 years. President Kennedy, whose assassination propelled Johnson to the Presidency, had failed to gain traction in Congress for Medicare. Johnson would succeed where Kennedy had failed, though not without the aborted effort of 1964 before final success in 1965.

Examination of the Johnson records reveals that the President clearly understood the importance of the way in which debate was framed, relied on a very select and tight group of advisors and staff to move the legislative agenda forward, had an extraordinary command of both the "big picture" and the details, and understood the importance of interpersonal relations with both supporters and opponents of his agenda.

That Johnson surrounded himself with some of the brightest political and economic minds of his time is virtually beyond dispute. Wilbur Cohen had been intimately involved with the Social Security Administration since its birth in 1935. He led the Administration's team on Medicare. Larry O'Brien, a holdover from the Kennedy Administration, and a close personal friend and advisor of the late President and the entire Kennedy family, managed the President's legislative affairs. The President's extensive history as a member and leader in both houses of Congress meant that he had an intimate understanding of parliamentary maneuvering and political logrolling, as well as the personal relationships necessary to promote his agenda in the legislature.

Wilbur Mills, the powerful Chairman of the House of Representatives Committee on Ways and Means, was instrumental in preventing Medicare's enactment prior to 1965. He was equally instrumental in its eventual passage in 1965. It appears that Mr. Mills was primarily concerned with three things: 1) not getting too far ahead of the Committee, i.e., he would not bring matters to a vote where he did not feel he had the votes to get his way; 2) not putting other Democratic Members of Congress in the position of casting votes requiring loss of some political support either way when passage of a bill was not certain; and 3) using the basic ideas of the opposition to strengthen the final bill by offering broader coverage while ensuring that the loyal opposition would have difficulty voting against the bill.

Finally, I examined media attention and public opinion. My examination of media attention was restricted to two major newspapers of the day, *The New York Times* and *The Los Angeles Times*. A count of relevant articles revealed that the topic appeared with relative infrequency over the time period, and that front page coverage was extremely scarce. Editorial articles comprised only a small fraction of the coverage. *The New York Times* largely favored the passage of Medicare on its editorial pages. *The Los Angeles Times* overwhelmingly opposed it. Public opinion, as reflected by The Gallup Poll's Most Important Problem Question, revealed that the public's attention was not very strong with respect to issues of Social Security, assistance to the aged, or Medicare during the 1964-65 time frame. The public, instead, was largely focused on foreign relations issues such as the Vietnam War and the ongoing threat of communism in the form of both Russia and Cuba, and on the race relations/civil rights issues that were commanding the attention of the government and the press during that period.

Therefore, neither the media nor the public drove the issue. Instead, it was the considerable efforts of two men: 1) the legislatively-experienced President, whose administration staff understood both the complexities of the proposed system and the political ramifications, and 2) House Ways and Means Committee Chairman Mills who was faced with little choice but to get out ahead of the troops and lead the way.

The successful passage of the Social Security Amendments of 1965 (P.L. 89-97) was, at that time, the culmination of a path that had been set in motion in the early days of the 20th century. Consistent with path-dependence theory, early decisions had lasting effects on the path. For example, President Franklin Delano Roosevelt's decision to forego national health insurance in the Social Security Act of 1935 (ch. 31, 49 Stat. 620) had the effect of leaving the path open to a fractured system of health care delivery and payment systems. With the formation of the Blue Cross and Blue Shield plans, private

coverage became available. As World War II and the remnants of the Great Depression heralded the Stabilization Act of 1942 (56 Stat. 765), unions were forced to negotiate wage increases (frozen under the Act) in the form of employer-provided benefit plans. This popularized, if not institutionalized, the nexus between employment and health insurance. Favorable tax treatment of these plans provided additional reinforcement to the early path decisions.

In spite of all of this, health insurance for the aged languished from its introduction in 1948 with the Wagner-Murray-Dingell Bill supported by Truman until its final passage in 1965. However, during that time, the Social Security Amendments of 1950 (P.L. 734) paved the way for direct payments (so-called "vendor payments") from the federal government to health care providers. The full impact of this policy materialized with the passage of the Social Security Amendments of 1960 (P.L. 86-778), which included the Kerr-Mills Amendments providing federal funding for state-level medical coverage for the medically indigent—the forerunner of Medicaid. This signaled a slight shift in the path towards more government sponsored coverage.

Had President Kennedy not been assassinated on November 22, 1963, it is questionable whether President Johnson would have ever been president. There is no way to know the answer to that question. However, as Johnson assumed the Presidency, the nation was in a state of crisis. This is similar to the state of crisis confronting President Roosevelt in the 1930s with the Great Depression. Johnson capitalized on the national sense of crisis to promote many of the plans envisioned by Kennedy, including Medicare. His ability to convert this into the liberal landslide of 1964, combined with his 24 years of experience in the legislative branch, gave him the markers he needed to push his legislative proposals through. That experience also gave him the knowledge of House and Senate rules and committee structures. He used that, along with his connections, to

reorganize the House Ways and Means Committee in early 1965 in such a way as to load the committee with Medicare supporters (David, 1985; Marmor, 2000; Oberlander, 1995). None of this would have likely happened without some early milestones in Johnson's career path, including his election to the House in 1936 and his rise to Senate Majority Leader before being elected Vice President (Caro, 1990, 2002; Goodwin, 1991).

As Arthur (1994) posits, path-dependence theory rests on four major principles: unpredictability, inflexibility, nonergodicity, and potential path inefficiency. No one would have predicted in 1935 that FDR's decision not to press for national health insurance would result in the fractured system of coverage that we have today (unpredictability). Similarly, it is unlikely that anyone involved in wage and price stabilization efforts in the early 1940s foresaw the nearly-unbreakable nexus it would create between employment and health insurance. The early decisions in the path have led to unpredictable results. In view of those early decisions, the path options did narrow (inflexibility) as time progressed. Even the passage of Medicare and Medicaid, admittedly a major policy shift, did not change the treatment-based approach and moral hazard culture of deductibles and co-payments that had by then become entrenched in American medical culture. Relatively small changes, such as the advent of vendor payments in the wake of the 1950 Amendments, or the AMA and Republican proposals in early 1965 did not cancel each other out but contributed to the final evolution of the policy in major ways as evidenced by Mills' three-layer cake. This is predicted by the nonergodicity component—small events not canceling each other out as noise—of path-dependence theory. Finally, Medicare and Medicaid's passage reinforced the fractured and negotiated nature of health care payment systems in the United States. As will be revealed in short order in this dissertation, the case can also be made that Medicare (and to a lesser extent Medicaid) has contributed to the spread between ordinary inflation and

medical inflation that has characterized the American medical system since 1965. As the elderly population has continued to grow, their political strength has also increased. The elderly are not likely to voluntarily relinquish any of their Medicare benefits in order to see universal care passed. They are certainly not as likely to use their political influence to pass new universal reforms as they would have been had they not been covered since 1965 by Medicare. Therefore, the path has led to an inefficiency of eventual outcomes. Whether that path inefficiency can be overcome remains to be seen.

Chapter 6:
The Path Between Johnson and Clinton

Johnson declined to run for re-election in 1968, knowing that Vietnam overshadowed any hope of his winning. Martin Luther King, Jr., was assassinated in Memphis on April 4, 1968. Barely two months later, Bobby Kennedy, the acknowledged forerunner for the Democratic nomination for President, was gunned down in the kitchen of the Ambassador Hotel in Los Angeles just after his victory speech for the California Democratic Primary. The party was in disarray. That November, former Eisenhower Vice-President and unsuccessful Republican nominee against JFK in 1960 Richard Milhous Nixon was elected President.

Democracy advances incrementally. When Johnson successfully managed the passage of Medicare in 1965, many saw it as an incremental step towards national health insurance. President Johnson (1971) said that Medicare "foreshadowed a revolutionary change in our thinking about health care. We had begun, at long last, to recognize that good medical care is a right, not just a privilege" (p. 220). Between 1960 and 1970, health care costs grew by more than 170 percent, prompting Nixon to ask what we were getting in return for all this money. Nixon focused his energy towards maintaining the current health insurance systems in the midst of a cost crisis. Edward Kennedy, having assumed the family mantle after his brother Robert's 1968 assassination, was considering a run for the presidency in 1972. His presidential hopes were dashed, however, by the Chappaquiddick accident in 1969 in which his young female passenger, Mary Jo Kopechne, perished. Still, Kennedy remained in Congress and a forerunner in pushing national health insurance, holding hearings around the country to increase support for such a plan. With aid from Wilbur Mills, chairman of the House Ways and Means

Committee (the same Wilbur Mills who had pushed Medicare through the 89th Congress), Kennedy led the charge (Weathers, 2004).

Nixon's first health bill, submitted in 1971, took the approach of utilizing lower-cost health care through an expansion of Health Maintenance Organizations (HMOs), combined with a companion bill that would require all employers to offer their employees a basic level of health care benefits. Fearing loss of its political base in the 1972 elections, the Nixon Administration returned to an antagonist position on universal health care. After the 1972 election, Nixon focused his energies on cost-containment with no intention of guaranteeing coverage to all Americans. Saddled with a sluggish economy, his proffered plans did little-to-nothing to reduce the gap in insurance coverage. Ultimately, the HMO bill passed but the employer mandate bill did not (H. Johnson & Broder, 1997; Weathers, 2004). This was the birth of so-called "managed care," a concept that we still live with today. I take note here of two points of foreshadowing with respect to the HMO Act of 1973. First, Dr. Paul Ellwood, a Minneapolis physician and proponent of managed care coined the term "Health Maintenance Organization" as an alternative name for prepaid health practices (like Kaiser Permanente). Second, Stanford economist Alain C. Enthoven promoted the concept in the policy circles of the time. Both Ellwood and Enthoven were key players in the Jackson Hole Group, the same group that devised the basic framework of the "managed competition" plan that President Clinton would propose, and fail to pass, nearly twenty years later. In fact, it was at Dr. Ellwood's vacation home in Jackson Hole, Wyoming, that the group met and from which it took its name (H. Johnson & Broder, 1997; Marmor, 2000).

It would appear that President Nixon's decision to pursue the HMO route to reduce medical costs was influenced, at least in part, by Edgar Kaiser. I remind the reader

that Kaiser had made a strong, but unsuccessful, attempt to have Medicare configured so as to provide a subsidy to prepaid comprehensive health plans like his Permanente organization in 1965. In a White House meeting between John Ehrlichman and Nixon on February 17, 1971 at 5:25 p.m., Ehrlichman discussed health care with the President. This conversation is on tape in the now infamous, and once legally embattled, Watergate tapes. Ehrlichman relayed to Nixon that he had asked Kaiser to come in and explain how the plan worked. Nixon was unenthusiastic about health plans until he heard Ehrlichman say "This is a – a – private enterprise one." That appealed to Nixon. Ehrlichman went on to explain that Kaiser is running his program for profit, and that the reason it works is that "[a]ll the incentives are toward less medical care because—the less care they give them, the more money they make…and the incentives run the right way." Nixon's response? "Not bad" (Rector and Visitors of the University of Virginia, 2003).

In spite of the move to managed care, medical inflation has continued to outstrip retail price inflation as measured by the Consumer Price Index. In 2005, the latest year for which figures are available, national spending on health care in the United States increased at double the rate of general inflation, for a 6.9 percent increase in health care spending (The National Coalition on Health Care, 2007).

Nixon resigned in disgrace in August of 1974 in the wake of the Watergate scandal. Gerald R. Ford assumed the presidency in a time of a crisis of confidence on the part of the American people towards their government. Ford's tenure was limited to just over two years as he lost the 1976 election to Jimmy Carter, a loss largely attributed to his pardoning of Nixon (Chafe, 1999). Ford's focus was largely on his "Whip Inflation Now" strategy. In spite of this, various health care bills continued to be introduced in Congress minus any from the Administration itself. Caspar Weinberger, then Secretary of Health, Education and Welfare, favored a program for insuring children of low-income

families. Weinberger resigned his post in August of 1975; Ford continued his moratorium on domestic spending programs (Weathers, 2004).

About this same time, scandal struck again bringing to a close the career of another strong national health care advocate, Democrat Wilbur Mills of Arkansas. Mills, longtime powerful chair of the House Ways and Means Committee, was found drunk in the company of an exotic dancer in 1974 (Green & Hornblower, 1974). He later admitted that he had spent much of 1973 and 1974 in an alcoholic haze and regretted not pushing national health care to the floor of the House in 1974 (Weathers, 2004).

In the 1976 elections, Jimmy Carter needed an edge against George Wallace. He reluctantly embraced a national, comprehensive, mandatory and universal health insurance program as the edge he needed. Elected in November of 1976, Carter immediately faced an economy that continued to worsen rather than cycling back to a position of strength. Elected by a slim margin, he dropped the universal health insurance idea until Edward Kennedy decided to run against him in the 1980 primaries. Meanwhile, his HEW Secretary, Joseph A. Califano, Jr., had tried to get a bill passed to help control hospital costs. That bill was derailed, at least partly due to the efforts, later publicly recanted, of freshman Representative Dick Gephardt (D-MO). Why Gephardt tried to derail the bill is not entirely clear. Less than two decades later, however, Gephardt would find himself as Senate Majority Leader leading the charge for the Clinton initiative. Interest rates and inflation continued to skyrocket. In 1979, Carter was trying to balance his need for support from labor (which had devised Kennedy's Health Security Act mandating employer-provided coverage for all employees) and his desire to take a more friendly position towards business than had been traditional among Washington liberals. Carter, a fiscally conservative Democrat, believed he had a mandate to cut government spending. He would prove an unlikely champion for anything as expensive as universal

coverage. Carter's own plan mirrored Kennedy's HSA with the proviso that private insurers would likely continue to be involved. In the end, his wishy-washy brand of politics, combined with the political split between himself and Senator Kennedy, would mean that national health insurance would have no chance of passage during his administration (H. Johnson & Broder, 1997; Weathers, 2004).

With the economy continuing to spiral out of control and the hostage crisis in Iran, Carter was not reelected in 1980. Instead, Ronald Reagan took the mantle in early 1981 as President. Reagan was a conservative of the first order. He clearly espoused what Lakoff (2005) would call the "strict father" style of governance. This is evident in his trickle-down economic plan (so-called "Reaganomics") as well as his dealings with the Professional Air Traffic Controllers Organization (PATCO) in busting their strike and eliminating the union. No one would ever realistically accuse Reagan of being a friend of labor. Reagan did, however, oversee the passage of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), which expanded Medicare benefits to cover outpatient drugs and capped enrollees copayments for other services. This law was repealed less than eighteen months later largely due to a public backlash led by those Medicare beneficiaries who had catastrophic coverage included in their employer-sponsored retirement benefits. These beneficiaries saw the 1988 bill as imposing additional premiums and taxes for relatively little benefit (Rice, Desmond, & Gabel, 1990). The backlash points to the importance of policy structure in any new health care legislation to be proposed. The financial burden of the coverage cannot look as though it falls only on certain individuals. In the case of the MCCA, a relatively high premium compared to the expected benefit for higher-income beneficiaries amounted to a perceived "tax on the rich." Depending on the mood of the country when health care next arises in Congress, this may threaten passage. From 1988 to 1992, there was no serious

attempt at national health care reform—not under Reagan, nor under George H. W. Bush (Weathers, 2004).

Chapter 7:
Too Much Money, Too Little Time:
Case Study of the William Jefferson Clinton Administration's Attempt at National Health care Reform

As with the Johnson case study in Chapter 5, this chapter is devoted to a chronological case study of the efforts of President Clinton, First Lady Hillary Rodham Clinton, the President's Task Force on National Health care Reform, and the administration in general to pass national health care in the first Clinton term of office. From my examination of more than 8,000 pages of presidential documents, primarily from the files of Domestic Policy Advisor for Health Care Chris Jennings, as well as other members of the administration, several key themes emerged. These are:

- A lack of available evidence that President Clinton remained actively engaged throughout the process, instead delegating the process to his wife. While Hillary Clinton had many of the skills necessary to do the job, opponents were able to paint her in a way that made her role, if not the woman herself, a target of public criticism beyond criticisms of the plan itself;
- Naiveté on the part of the Clintons and many administration staff members with regard to the legal and political ramifications of their decisions;
- A propensity to make the plan fully their own, sharing little credit for its development with Congress;
- An attempt to incorporate (and, to a great extent, mollify) the existing corporate structures of health care delivery in the United States, e.g., insurance companies, hospitals, clinics, and corporate physician practices; and

- Extended time from launch of the task force to delivery of the administration's overly complicated proposal giving opponents time to marshal their forces in opposition to the plan.

First, one might say that it is not possible to discern President Clinton's level of engagement because of the limited record available for examination at the time the data were gathered. However, as Chris Jennings was the lead domestic policy adviser for health care, it is reasonable to presume that most of the correspondence would have passed through his hands and be found in his files. Jennings' files represent the bulk of the files I examined in the Clinton Presidential Library and they lack evidence of President Clinton's direct involvement in much of the process. Additional health care files from Domestic Policy Adviser Carol Rasco and Director of the Domestic Policy Council Bruce Reed (who has served, since 2001, as president of the Democratic Leadership Council) yielded no additional evidence of President Clinton's direct involvement in the process.

Admittedly, many Clinton administration records have yet to be released. The primary reasons are that staff have not had time to process the millions of documents in the archives and, perhaps more importantly, restrictions on what can be released and what must be redacted. However, with respect to the second reason, redactions from the files are noted in redaction memos which specify sender, recipients, and type of document or correspondence. In all of the examined files, only four redaction entries indicate "POTUS," the acronym for "President of the United States" as a recipient. No other redaction record mentions the President either by name or by title. While one might reasonably presume that the President stayed informed of the process through his daily interactions with the First Lady, the record does not indicate that other advisers or outside parties delivered documents on the topic directly to the President. Either the President

was relatively disengaged from the process, or the First Lady maintained tight control over what got through to the President in written form.

Second, the naiveté of the Clintons and other members of the administration with respect to the legal and political ramifications of their decisions can be illustrated with several examples. The selection of Ira Magaziner, a long term friend of the Clintons, to be co-chair of the task force is indicative of the high degrees of trust placed in decision makers who were, to say the least, not intimately acquainted with the processes and politics inside Washington. Even the naming of the group as a "task force" had legal ramifications, especially in terms of the First Lady's involvement as co-chair of the President's Task Force on Health Care Reform. The upshot of these ramifications was that all of the task force's working papers had to be made public in response to a Freedom of Information Act lawsuit, primarily because the First Lady was not a paid employee of the government (H. R. Clinton, 2003). Had anyone bothered to check with White House counsel, this mistake might have been avoided. Finally, and perhaps most dramatically to this point, the belief on the part of the administration that they could force the bill through the Senate as part of a reconciliation bill, which would have eliminated the possibility of a filibuster requiring 60 votes to bring cloture to the debate, proved fatal in the end as neither Hillary Clinton nor the President was able to persuade Majority Leader Robert Byrd (D-WV) to waive his "Byrd rule," which states that only budget issues may be included in reconciliation bills.

Third of these "themes" is the propensity of the Clintons and the administration to make the plan fully their own without sharing credit. This is primarily evidenced by two events: 1) Bill Clinton's naming of First Lady Hillary Rodham Clinton to co-chair the task force; and 2) not one, but two, separate ceremonies on Capitol Hill to deliver the final proposed legislation. In the first case, the effect of naming the First Lady to chair

such an important policy task force was certainly a historical first. No previous president had ever appointed his First Lady to such a role. Though other First Ladies have been known to exert influence on political matters with their husbands, none had ever played such an important role in a presidential administration is such a public way. Hilary Clinton's appointment had the effect of placing a very hot spotlight on the process and raising the political stakes for Republicans to hand the Clintons—husband and wife—a major defeat before the first mid-term elections. In the second case, following a delay of eight months, the President made a speech to a joint session of Congress to discuss his Health Security Act. However, the plan was not yet ready and it was more than a month later that the Clintons returned to Capitol Hill for the final delivery of the complex bill comprising more than 1,000 pages. In a March 11, 2009, interview with Dr. Sanjay Gupta on *Larry King Live*, Bill Clinton disclosed that he wanted Congress to write the legislation, but Ways and Means Chairman Dan Rostenkowski (D-IL) insisted the administration draft it so that the committee could amend it (Hirzel, 2009). I had found no support in either the files (i.e., primary source documents), nor in the secondary sources for this statement by the former President.

The fourth major "theme" from this case study relates to the extended period of time from the launch of the task force to delivery of the legislation. In the case of the Johnson administration, the Medicare bills were, respectively, H.R. 1 and S. 1, and both were introduced very early in the 1965 session of Congress, having failed in the 1964 session.. President Clinton appointed his task force just five days into the President's first term of office, and he wanted a plan delivered during his first 100 days in office. However, it took 10 months to produce the plan, and the plan was not introduced until mid-November of 1993, nearly the end of the first session of the 103rd Congress. These delays permitted opponents of the plan (e.g., Hospital Insurance Association of America,

American Medical Association, and others) to marshal their forces in opposition to the President's plan. In fact, the President made a nationally televised address to a joint session of Congress on September 22, 1993, in which he outlined the major points of his plan. Yet, it was nearly another two months, and just days before Congress recessed, before the actual bill was introduced in the two houses. This lengthy interim, again, gave ample opportunity for the opposition to begin to work public opinion and the media in order to lay down political cover for the Republicans to ultimately defeat the Clinton proposal.

I turn now to the detailed and chronological case study of the Clinton effort. This study is taken from the Clinton Presidential Library files and is triangulated with secondary published sources as previously discussed.

THE PRESIDENT'S TASK FORCE ON NATIONAL HEALTH CARE REFORM

William Jefferson Clinton, 42nd President of the United States of America, wasted no time in addressing health care. Five days into his presidency, on January 25, 1993, Clinton announced the formation of the President's Task Force on National Health Reform to be headed by his wife First Lady Hilary Rodham Clinton and co-chaired by long-time Clinton associate Ira Magaziner. Magaziner and Clinton met when they were Rhodes scholars at Oxford. Magaziner was a successful business consultant before joining the Clinton White House as the President's senior advisor for domestic policy development. He later served as senior advisor to the President on the Internet (W. J. Clinton, 1993b). Clinton's initiative towards comprehensive, universal coverage became mired in details and eventually failed to gain passage, but its story is worth telling. Ultimately, this failure became a major factor in the loss of control of both the Senate and the House by Democrats in 1994 (Hacker, 1997; Hacker & Pierson, 2005; H. Johnson & Broder, 1997).

The Clinton task force's work was supported by people from across agencies of the government, staff representatives from the Legislative Branch, state officials, and private sector participants such as academics and policy advocates. This group, envisioned and created by Magaziner, originally was to have fewer than 100 members, but grew quickly to something in excess of 600 members as more constituencies raised their hands and demanded seats at the table (H. R. Clinton, 2003; H. Johnson & Broder, 1997). This group became known as the Interdepartmental Working Group (IWG).

On February 24, 1993, the American Association of Physicians and Surgeons (AAPS) filed suit against Hillary Rodham Clinton and others to force open the records of the Task Force and the IWG pursuant to the Federal Advisory Committee Act. This litigation extended into late 1994 when the White House, in an attempt to end the lawsuit, announced the release of the IWG records through the National Archives and Records Administration. The announcement was made August 17, 1994, and the records were first opened to researchers on September 7, 1994. The records are now housed at the Clinton Presidential Library in Little Rock, Arkansas and comprise 689 boxes of files and other records (National Archives and Record Administration, 1994).

IWG's primary organizational and feedback mechanism were so-called "tollgates," meetings held approximately every two weeks where each subgroup of the IWG would report its work and findings to Magaziner. These meetings, held almost around the clock, created a lot of discussion and input, but in the end, many participants felt that the Clintons and Magaziner would do whatever they wanted to anyway. The general feeling was that the purpose was more to be able to say that they had consulted and built a plan based upon the input of many persons, agencies, and organizations (H. Johnson & Broder, 1997).

At least some Democrats were anxious to make their views known to the First Lady and the task force. As an example, on April 26, 1993, David Prior, Democrat Senator from Arkansas, Chairman of the Senate Special Committee on Aging, and a Clinton political ally, sent a letter to Mrs. Clinton in her role as chair of the task force outlining his thoughts on reform of the pharmaceutical sector. Among the topics that Pryor discussed is using the power of Medicare to negotiate prices with drug manufacturers (Pryor, 1993). Pryor's office also released the major points of the letter, and the fact of its existence, to the press on the same day as the letter was drafted (Senate Committee on Aging, 1993). Around this same time, *The Wall Street Journal* reported that market pressures were causing some pharmaceutical companies to lower their drug prices in order to remain competitive (Tanouye, 1993). Apparently, Pryor's analysis garnered some weight within the task force, as evidenced by an analysis performed by Dr. Sophie Korczyk (1993) and submitted on April 30, 1993.

Pharmaceutical costs were one of many important considerations in formulating the new bill. A briefing book for the President and the First Lady prepared by the Working Group on Pharmaceutical Access and Cost Containment (1993) comprised 42 pages of discussion and bullet points on the matter. Perhaps the most revealing aspect of the briefing book is that price controls in the form of caps were being considered at that point, at least for the short-term control of drug prices. Additionally, at least some consideration was being given to whether seniors covered under Medicare would receive drug benefits if they were included in the final bill for younger Americans. It was recommended "as a matter of equity" (p. 23) that an outpatient drug benefit plan be developed for Medicare as coverage for older adults was not likely to be folded into the national plan immediately. In an equally poignant question-and-answer that demonstrates that at least someone in the group was aware of the historical path on which they found

themselves, a reference is made to the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360), passed under Ronald Reagan, and which Medicare beneficiaries so summarily rejected that it was quickly repealed. The question in the briefing book goes to whether older Americans will support a drug benefit under Medicare. The answer is that the MCCA benefit was financed solely by Medicare beneficiaries while the proposed benefit here would be subsidized from general revenues making the financing "more broadly-based" (p. 42).

Apparently at least some pharmaceutical companies were concerned about the potential for price controls. *The Wall Street Journal* reported on April 27, 1993 (as cited in Searle Corporation, 1993) that the administration was considering the option of voluntary cost-control agreements in lieu of actual mandated price controls, a fact borne out by multiple files in the Chris Jennings' files of the IWG. On April 28, Rx Partners, an industry group comprising Searle, Upjohn, Hoffmann-LaRoche, Warner-Lambert, Eli Lilly, and Bristol-Myers Squibb, issued a press release responding that the member companies were ready to cooperate with the Administration to control costs (Searle Corporation, 1993). Kurt A. Furst (1993), Director of the Searle Washington Office, faxed a copy of the release to Chris Jennings with a note calling attention to the "supportive tone" of the response and suggesting that "If a formal submission of the health care plan to the Hill is delayed, why not utilize the extra time to sit down with progressive industry representatives and work out a viable plan?" (p. 1).

Price controls on medical care had historically failed to curtail medical inflation in the long run. In August of 1971, President Nixon had imposed wage and price controls on an economy that was suffering what was, at that time, historically intolerable peacetime inflation. On April 30, 1974, price controls on medical care were lifted, a year later than price controls on other sectors of the economy. Over the period of the controls, medical

inflation had been held to 4.9 percent annually, compared to general inflation rates averaging 5.2 percent. However, medical providers were simply holding price increases for later. The first year after the controls were removed, medical inflation hit 12.1 percent, a full 2.9 percentage points ahead of general inflation. In 1975, they remained three points ahead of general inflation (Starr, 1982). An internal document of unknown authorship indicated that the task force knew this history ("The dangers of price controls," 1993).

IWG staff were not the only ones frustrated by the sense of being ignored. Republican Congress members were equally frustrated. Senator Dave Durenberger (R-MN) said “By May, when Hillary knew she wasn’t going to have a bill for a long time, she started coming up here and doing that PR thing so at least she could say Republicans are being consulted. The reality is we may have been consulted, but we weren’t involved” (H. Johnson & Broder, 1997, pp. 131-132).

Within the administration itself, Magaziner had his detractors. Secretary of Health and Human Services Donna Shalala and her close friend Alice Rivlin, then deputy director of the Office of Management and Budget, expressed serious misgivings directly to the Clintons about the process Magaziner outlined. Their advice fell on deaf ears (H. Johnson & Broder, 1997).

A full exploration of the documents relating to the IWG and the Task Force is beyond the scope of this dissertation. However, two important points have been made in the literature surrounding the Clinton effort that deserve attention here.

First, many have suggested that the Clinton Administration was largely staffed by people who were too young and too inexperienced for the positions they held (a charge that had also been leveled about War on Poverty programs). That may or may not have been the case. What is apparent, in the case of health care, is that mistakes, sometimes of

a seemingly inconsequential nature, were made that caused later headaches. A prime example was calling the group a "task force." Though this may seem like a trivial point to the uninitiated reader, this unfortunate terminology formed the basis for the AAPS lawsuit which claimed, among other things, that the meetings of the task force were subject to open meetings laws, and that the First Lady, who was not a federal government employee, was not allowed to attend or chair closed meetings (H. R. Clinton, 2003; H. Johnson & Broder, 1997). According to Johnson and Broder (1997), Hillary Clinton never attended another task force meeting after the suit was filed. Bob Boorstin, who managed communications on health care for the administration, said "If I'd called it a working group, there never would have been a question about Hillary. We were young and stupid and we didn't check with legal counsel" (H. Johnson & Broder, 1997, p. 112). Indeed, in reviewing the files of the Domestic Policy Council, and in particular those of Chris Jennings, Bruce Reed, and Carol Rasco, I found very few indications that the Office of the White House Counsel was consulted during the process.

The second picture that emerges is of an administration that was woefully unaware of the rules of "inside baseball" that permeate political Washington. Dick Morris (D. Morris & McGann, 2004), a pollster and political consultant who worked with the administration at various points, recounts meetings with the President after the 1992 election and prior to the inauguration. Morris recalls telling the President that he did not have the necessary 60 votes in the Senate to break a Republican filibuster. Morris and McGann recount that the President spoke of utilizing public opinion to force Republicans in his direction or of getting enough liberal Republicans to join forces with the Democratic majority to close debate. But, according to Morris & McGann (2004), "it was clear he had no idea what he was up against" (p. 155). Other examples abound, including underestimating resistance from Senator Daniel Patrick Moynihan (D-NY) based on his

perception that at that point, Clinton had abandoned the promised welfare reform in favor of health care reform (H. R. Clinton, 2003; H. Johnson & Broder, 1997; D. Morris & McGann, 2004; Weathers, 2004). Likely the most important example was underestimating Senator Robert Byrd's (D-WV) objection to including health care reform as part of the budget reconciliation bill, which would have limited debate without the need for a supermajority to break a filibuster. Reconciliation bills, under Senate rules, are not subject to filibuster. The Clinton team considered this the most likely route to passage. One man blocked that route (H. R. Clinton, 2003; H. Johnson & Broder, 1997; D. Morris & McGann, 2004). In her memoirs, Hillary Clinton (2003) concedes that she later came to agree with Byrd's contention that health care was simply too complex a problem to be subjected to limited debate.

The task force ended its work on May 31, 1993 (H. Johnson & Broder, 1997). The President had asked for a bill to be ready to submit to Congress within 100 days. With 127 days gone, the task force had not yet prepared a bill that was ready to submit, but the effort was far from over. Let us now turn to the files of Chris Jennings, domestic policy advisor for health care, and others from the Clinton Presidential Library to see how the Administration tried, and ultimately failed, to pass the Health Security Act.

AFTER THE TASK FORCE – MAY, 1993 TO SEPTEMBER 1994

Before launching into the examination of the records, I should explain the sources chosen and the rationale behind those choices. The primary source available at the time of this research in the Clinton Presidential Library, beyond the IWG files, were the files of Chris Jennings, the White House domestic policy advisor for health care. It could be said, and would certainly be true, that these files were selected out of convenience, since they were the files that were open and available at the time. However, Jennings' files are likely the most complete source of information among all available files that covered the

period after the end of the task force itself. Almost every correspondence related to the matter would have passed at some point through Jennings' hands or that of his office staff. I also examined Jennings' files from the IWG.

Additionally, I examined Domestic Policy Council files, and in particular, those of Carol Rasco and Bruce Reed. Rasco served as a domestic policy advisor (H. Johnson & Broder, 1997), and Reed was chief domestic policy advisor and director of the Domestic Policy Council. From 1990 to 1991, when Bill Clinton was chairman of the Democratic Leadership Council (DLC), Reed served as its policy director. Today, Bruce Reed is President of the DLC (Democratic Leadership Council, 2008). Finally, I looked at selected files of the White House Press Office, including press releases relevant to the work of the Task Force and Administration efforts to pass the Health Security Act.

Before the task force finally shut down on May 31, 1993, the White House was already considering how particular outside interest groups could be persuaded to come aboard. A memo to the First Lady from Special Assistant to the President for Public Liaison Mike Lux (1993) on May 5, 1993 has the subject: "Closing the Deal With Interest Groups" (p. 1). This was almost five months before the President's address to Congress proposing the Health Security Act. In the memo, Lux breaks the groups into three categories: 1) Groups essentially ready to come aboard; 2) Groups still negotiating with the task force over key details, but likely to end up supporting the bill (the National Association of Social Workers was listed in this category); and 3) major organizations whose position would depend on major policy decisions not yet made. This last group included the AMA, Blue Cross/Blue Shield, the Big Five Insurance Companies, pharmaceutical and druggist associations, and the American Trial Lawyers Association. Lux pointed out that once the key policy decisions were made internally, they would

"know whether we should proceed with a 'close the deal' strategy or a 'how do we manage the opposition' strategy" (p. 2).

Meanwhile, the First Lady had been busy working the Hill, meeting with Senators and Representatives as well as their staffs. In spite of the fact that she had been out of Washington, D.C., for most of the period from March 19, when her father Hugh Rodham suffered a massive stroke in Little Rock, until his funeral in early April (H. R. Clinton, 2003; H. Johnson & Broder, 1997), Hillary had managed to attend most of the 71 congressional meetings that had been held by key task force members. These included 28 Senate meetings, 32 House meetings, and 11 with representatives of both houses. Forty-five of the meetings had been held with Democrats only, while 10 were bipartisan meetings, and only 6 were held with Republicans only. All but eight senators had met with the First Lady. The eight remaining included Democrats Joseph Biden (D-DE), Robert Byrd (D-WV), and Richard Shelby (D-AL) and Republicans Hank Brown (R-CO), Alphonse D'Amato (R-NY), Trent Lott (R-MS), John McCain (R-AZ), and John Warner (R-VA). The First Lady or her designees had met with 28 of the 175 House Republicans and 131 of the 255 House Democrats in the course of the 71 meetings (Jennings & Edelstein, 1993b).

The First Lady (H. R. Clinton, 2003), in her memoirs, noted that "Every Democratic emissary we could think of, including the President, had asked [Senator Byrd] to allow health care reform into reconciliation. But on March 11, [1993], in a phone call with the President, the Senator said he objected on procedural grounds and that the 'Byrd Rule' would not be waived" (p. 154).[8] Yet, on May 5, almost two months

[8] The Byrd Rule prohibits the Senate from considering anything extraneous to the budget as part of a reconciliation bill. The reconciliation process, under Senate rules, is not subject to filibuster. Therefore, it is not necessary to obtain a 3/5 majority (60 votes) in order to pass a reconciliation bill. For this reason, it is often deemed desirable to include in reconciliation bills other things that might be blocked by the minority party using the filibuster. The Byrd Rule prohibits this by excluding "extraneous matter" from the reconciliation process. It is enforced by raising of a point of order. If the point of order is sustained, the

after the reported date of the phone call, the memo recapping meetings with Senators and Representatives explicitly states that the First Lady had not met with Senator Byrd (Jennings & Edelstein, 1993b). A review of the 27-page memorandum, which includes extensive lists of all such meetings whether with the First Lady or any other member of the task force team or the President, shows no meetings at all on any count with Senator Byrd. If the record is correct, the First Lady herself had never met face-to-face with Byrd to press for including health care in the reconciliation bill.

In June, at the urging of Senator Tom Daschle (D-SD) and House Majority Leader Dick Gephardt (D-MO), the First Lady asked for a proposal for a "Health Care University" to offer legislators presentations on health care issues. These meetings were to be open to legislative Members of both parties ("Health Care University Concept/Implementation Proposal," 1993). The proposal was developed and circulated. On July 27, 1993, a staff meeting was held to discuss the Health Care University and to review materials being prepared for distribution to Congress before the August recess (Jennings & Edelstein, 1993a).

The Health Care University meetings took place in late September, 1993. Among the speakers was former Surgeon General of the United States C. Everett Koop, a Reagan appointee (Koop, 1993). Koop indicated that the President had told him that he viewed the health care proposals "not as a take-it-or-leave-it package, but as what they are – proposals: proposals that will lead to constructive debate, and not just to constructive debate, but then to constructive legislation" (p. 1). Koop acknowledged that he had some disagreements with the proposal draft he had read, but found it to be sufficiently detailed, and that his concerns would not "stop [him] from fighting for the many reforms the

---

provision is excluded from the bill unless the proponents can get it waived by a 3/5 majority. This is important in the current political context as well as the Clinton historical context as the Obama administration is considering putting its health care reform spending plans, as well as other controversial matters, into reconciliation bills. They may learn the same lesson that the Clintons did in the end.

American health care system so desperately needs" (p. 2). He went on to note that over the prior months, physicians, nurses, hospitals, patients, pharmaceutical and insurance companies and others had begun to reform themselves. Very likely, he was referring to such things as the noted decrease in premiums, hospital billings, and prescription drug costs that had occurred in response to the pressure of an unwanted national health care reform package.

Koop (1993) clearly had an understanding of the path that health care reform had taken. He also had an interesting theory about the forces that had continually interacted in the health care debate: individualism and altruism. He attributed the last major reform effort – Medicare and Medicaid – to altruism, and to the fact that it "happened at a time when we thought we could afford it" (p. 3). Koop saw individualism as presenting some of the more intractable problems in passing health care reform "as physicians insist upon autonomous practice, hospitals want to make market choices but be free from market competition, insurance companies want the freedom to deny coverage to high-risk people, pharmaceutical companies want to control development and distribution of their products, patients want choice in access to care without gatekeepers or waiting lines, and taxpayers want more money for themselves" (p. 4). In this relatively short speech, the former Surgeon General had encapsulated both the motivators and the barriers to passage.

Finally, Koop (1993) espoused the idea that the problem driving health care costs (and medical inflation) could be found in the irony that while some Americans had too little health care, a great many had too much health care. Universal insurance, then, could have the effect of driving costs higher. This, in fact, is one of the lasting impacts of Medicare and Medicaid. More people, in that case elderly people who would have a tendency to have more demand for care, were granted access to a plan where such care was largely paid for by government dollars. The simple laws of supply and demand had

driven the costs higher and that quite quickly. Koop admitted that little was known about what worked in this costliest of American enterprises, and that patients were getting tests and procedures from doctors who did not fully understand those tests and procedures. He estimated that 25-30 percent of medical care was medically unnecessary. He called for greater outcomes research to battle these forces and control costs over a projected five year period. He called for changes in the medical education system and a move from an emphasis on "curing" to an emphasis on "caring" (p. 7).

Shortly before the disbanding of the President's Task Force on Health Care Reform, the Republicans, under the auspices of the Republican Caucus of the House Committee on the Budget, put out a White Paper on Health Care Reform (Kasich & Republican Members House Committee on the Budget, 1993). The 24-page report is essentially a position paper on freeing the health care market, putting consumers back in charge of negotiating their own care (and the prices for it), and reducing government spending on health care which has put upward pressure on costs. Notably, access to health insurance is addressed briefly under the heading "Additional Concerns for Reform" (p. 12). In this section, the Republican authors of the paper rely heavily on the argument that access to health insurance is not the same as access to health care because no one is denied access if they present themselves for treatment at an emergency room. The White Paper was issued "as a contribution to the House Republican Leader's Task Force on Health Care" (p. 1). I have found no reference to this task force in any of the literature surrounding the Clinton health care reform efforts.

The Kasich et al. (1993) White Paper puts forth what has been the consistent Republican approach, not only to health care but to myriad other cases: free market economics. The paper, perhaps unintentionally, also gives credence to the path-dependent nature of health care in that it quite correctly states that a) government spending on health

care increased in the wake of Medicare; b) those increases contributed to the rapid rise of costs of health care; c) tax-favored treatment of employer-based health insurance had acted as a premium subsidy to mostly larger employers and their employees; and d) consumers were insulated from market-based decisions (that is to say price-based decisions) about their health care as were doctors and other treatment professionals. Notably, these conditions remain in effect today, especially the tax-favored treatment of employer-based plans and consumer insulation from market-based decisions.

Where the Kasich et al. (1993) White Paper fails, perhaps unintentionally, is in the description of the "free market" for health care. The paper makes no allowance, for instance, for the fact that such a market is hampered by asymmetric information—consumers have very limited information about the "market price" of any given procedure or service. In the absence of that information, the purchaser is at a disadvantage in the marketplace and market power accrues to the providers. This point is examined more closely in Chapter Nine "The Road to Somewhere." The White Paper, in fact, advocates that consumers should be more directly responsible for negotiating their own price structures in lieu of the present market structures in which insurance companies and large self-insured employers negotiate those structures on their own behalf, and presumably on behalf of their plan participants. In other words, the Republicans advocate an individualist approach, even preferring individual coverage over employer-based group coverage in this paper, rather than having large employer-based groups collectively negotiating price structures. This should come as no surprise to the informed reader who recalls the union-busting days of the Reagan Administration.

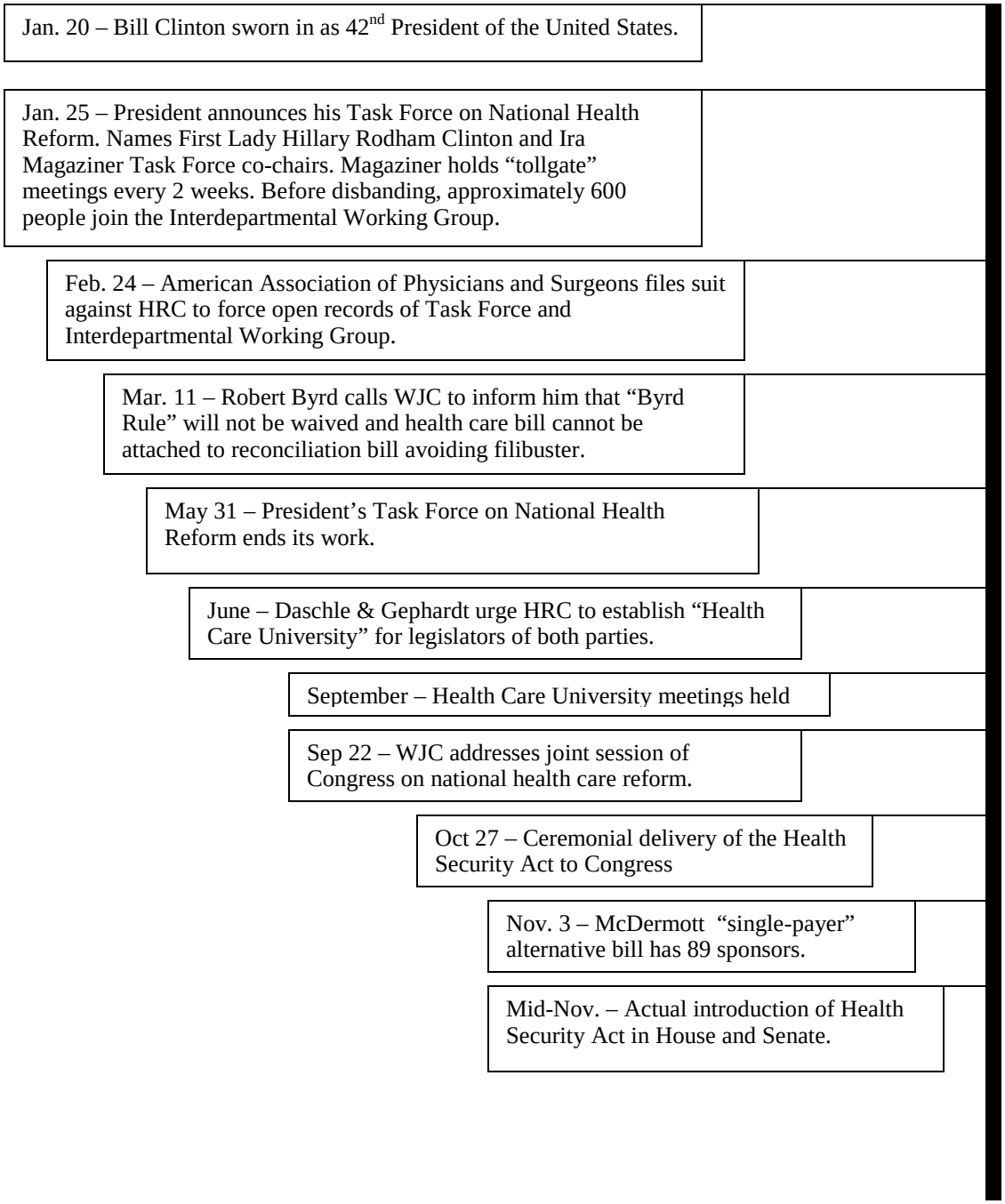


Figure 10: Timeline for January 20, 1993 to December 31, 1993

We do know that the First Lady was aware of the Kasich et al. (1993) White Paper, as it was supplied to her in a briefing packet on Saturday, June 12, 1993 (Tilley,

1993) as she prepared for a dinner at Congressman Kasich's home the following Monday, June 14. The dinner is characterized in the schedule (Office of the First Lady, 1993) as an "Informal dinner/Open discussion on health care" (p. 600). Approximately 12 people were to attend the dinner, including the First Lady, three of her staff, and presumably Kasich. The record does not indicate who the other attendees were.

Republicans were clearly not sitting idly by as the administration worked on its bill. Senator John Chafee (R-RI) led the Republican effort to craft a health care reform bill. The Jennings files contain a comparison ("Comparison of Chafee/Dole legislation to Clinton proposal," n.d.) of the anticipated Chafee bill to the Clinton proposal, based on the 1992 Chafee/Dole bill. The unknown author of the comparison anticipated that the Chafee plan would likely have individual mandates but no employer mandate; would create a federal system to encourage early settlement of malpractice disputes; would be similar to the Clinton proposal in shifting the focus of health care to early intervention, preventative, and primary care; would propose a standard minimum package of benefits similar to the Clinton proposal (though likely not as comprehensive in nature as the Clinton plan); and would have a smaller, and thus weaker, version of purchasing alliances compared to the Clinton plan.

The administration was well aware by summer that they would have a battle on their hands over health care reform. In a July 20, 1993 memo to Jeff Eller, the White House communications aide charged with running the Health Care War Room (H. Johnson & Broder, 1997), with the subject "Fight Strategy," Chris Jennings and Steve Edelstein (1993c) outlined their assessment of the battle before them. They believed that "the most extreme elements of the Republican party" would lead the opposition. Jennings and Edelstein rightly assessed the coming conservative portrayal of the Clinton proposal as "too expensive, harmful to American business and the economy, over-reliant on

government regulation, and limiting physician choice and rationing care." They also accurately predicted the alliances between the conservative members and outside organizations such as the National Federation of Independent Business (NFIB) and the Health Insurance Association of America (HIAA), though the memo gives no indication that the Administration had any inkling of the overwhelming importance those alliances would come to have in the debate. It is worth remembering here that it was the HIAA who produced and promoted the "Harry and Louise" ads depicting a middle-class couple fearful about the effects of the Clinton plan on their health care.

One of the prime arguments against the Clinton proposal was that employer mandates would cause job losses. In mid-July, Richard Hinz (1993) of the Department of Labor produced a memo for the First Lady outlining, from a strictly economic point of view, the elements of the widely-ranging job impact analyses. The bottom line of this analysis was "[a] reasonable expectation...that there will be some employment losses concentrated among very low wage workers and in small businesses because they do not currently provide health benefits to these workers" (p. 2). According to the Hinz memo, the NFIB had sponsored a report indicating "some [estimates] as high as 15 to 20 million" lost jobs. Hinz called the NFIB studies "essentially meaningless" (p. 2) because they did not incorporate the key elements and processes of analysis. Hinz may well have been correct in his assessment of the NFIB studies *from a purely economic/scientific point of view*. Political reality, however, can be quite different from economic reality or anything produced by the scientific method. Producing studies designed to scare the public and thereby provide political cover are standard fare for politicians, and it is well-known that certain political factions have devoted a great deal of energy and money to largely very successful efforts to produce such "science" and use it to frame the political

debate in ways that are most effective for their positions (Hacker & Pierson, 2005; Lakoff, 2004, 2006).

As the summer of 1993 ended, the White House was gearing up for Congress to return from its August recess. The President's speech announcing his health care reform bill was approaching in late September. About three weeks ahead of the speech, an internal memorandum (Yager, 1993) listed all of the businesses and business associations whose representatives had met with some member of the task force along with an assessment of the position of each with respect to the Clinton plan. The assessments were on a four-point scale which included: a) Likely support; b) Maybe or unclear; c) Helpful, but not endorse; and d) Unlikely. Of the 150 businesses or business associations listed in the memo, only 21 were categorized as likely supporters of the Clinton proposal. Nearly twice as many (40) were believed to be unlikely to support the plan, with 80 of the 150 listed as "maybe or unclear." This last group likely reflected the fact that the proposal in its final form as the Health Security Act was still almost sixty days from release, and was, thus, not yet adequately solidified for this group's assessment of support.

On September 22, 1993, at 9:10 p.m. Eastern Time, Bill Clinton stood in the House chamber before a joint session of Congress to deliver his address on national health care reform. In spite of serious problems with the teleprompter at the beginning of the speech, he delivered a convincing address. Pollsters for both parties found that public response to the televised address was overwhelmingly positive (H. Johnson & Broder, 1997). Naturally, it was the President who gave this nationally televised speech, but the First Lady was not going to be out of the main spotlight for long. At the conclusion of the speech, the President, Vice-President Gore, and Mrs. Gore returned to the White House and dropped in to the Health Care Task Force War Room. Meanwhile, the First Lady remained on Capitol Hill for a live interview with Dan Rather of CBS News. The next

morning, prior to the afternoon health care rally, she taped interviews with Paula Zahn (CBS Morning News), Joan Lunden (ABC's Good Morning America), Katie Couric (NBC's Today Show), and Judy Woodruff (CNN). Clearly she was staying in the spotlight (Office of the First Lady, 1993).

The next day, the President spoke at a rally for supporters on the South Lawn of the White House. Nearly 70 representatives of groups supporting the Clinton health care reform plan were slated to appear on stage with the President (including Dr. Ann Abbot, President of the National Association of Social Workers), and hundreds more were invited to attend. The press office released a list of invitees along with a large packet of letters of support from those in attendance (White House Office of the Press Secretary, 1993a). How well did the White House gauge the strength of these supporters? One striking example, involving someone who would later become quite notorious, can be seen in the files.

On September 28, just five days after the South Lawn event, an internal memorandum (Lux & Yager, 1993) was circulated listing "groups, CEOs, and business owners [who] would be the best testifiers to Congressional Committees from our perspective" (p. 1). Among those on the list was Kenneth Lay, Chairman and CEO of Enron Corporation. However, a closer examination of Lay's (1993) letter of support (included in the previously mentioned press packet), reveals his "commit[ment] to reasonable and equitable reform of the health-care system." Lay then defines what he means by the statement:

> [A]ll Americans should pay for a portion of their health-care bills thereby becoming informed consumers; a competitive health-care system must be nurtured where the most efficient and highest quality providers will flourish; the current legal system must be reformed to reduce the deadweight cost of unjustified malpractice lawsuits and the enormous cost of defensive medicine to prevent them; and uniform administrative processes need to be implemented which will greatly reduce the administrative cost of all health care.

Even the most generous reading of Lay's letter does not reveal an overwhelming support for either progressive principles or the employer mandates envisioned in the Clinton proposal. Lux and Yager (1993) had, in at least one case, misunderstood the "support" being offered.

The same day, September 28, the First Lady testified before the House Ways and Means Committee and the House Energy and Commerce Committee. On the 29th, she testified before the Senate Labor and Human Resources Committee in the morning and the House Education and Labor Committee in the afternoon. On the morning of the 30th, she testified before the Senate Finance Committee, chaired by Daniel Patrick Moynihan (D-NY) and taped an interview with Larry King that afternoon (Office of the First Lady, 1993)

On October 1, an event took place that has little to do with the path-dependence per se of health care policy, but illustrates at least some appreciation of its history. The First Lady traveled that day to New York City to attend the Lasker Awards Ceremony, a function of the Lasker Foundation whose benefactors Albert and Mary Lasker had been early pioneers of medical research. The Laskers had also been early champions of the Wagner-Murray-Dingell Bill, forerunner of Medicare, during the Truman administration. While at the event, Mrs. Clinton had a photo op with 93-year old Mary Woodard Lasker herself (Office of the First Lady, 1993; The Lasker Foundation, 2008).

Public and organizational sentiment was running high in support of the President's plan. The actual bill, however, was still not ready for delivery to the Hill. A ceremonial delivery of the bill (the actual bill was still not ready) took place on October 27, more than a month after the President's address to Congress and the South Lawn rally. The event, held in the old House chamber, included remarks from both the

President and the First Lady. Among other speakers invited to address the group was House Minority Leader Bob Michel (R-IL), a moderate Republican. Unexpectedly, Michel delivered "an unsparing attack on the very premise of the Clinton plan" (H. Johnson & Broder, 1997, p. 191). Michel concluded his remarks, laying down the gauntlet of opposition, by framing the debate as a battle between the private-sector system that had provided care for so many and "an uncharted course of government-run medicine" (Michel, B. as quoted in H. Johnson & Broder, 1997, p. 191). This signaled that Republicans were ready to mount a full frontal attack on the Clinton plan, which would have been unlikely had they not believed that public support for the Clinton plan was rapidly eroding.

In the month between the September address and the October ceremonial (but not actual) delivery of the Clinton bill, trouble had erupted in Somalia and Haiti, creating a situation in which the President was forced to cancel nearly every scheduled health care event (H. Johnson & Broder, 1997). At the very least, foreign affairs overrode his focus on the Health Security Act. On top of the myriad delays in getting a proposal before the Congress, the act seemed all but stillborn.

Problems on the foreign affairs front were not the only issues to crop up in October. As sometimes happens with large organizations (and there is no larger organization than the federal government), enthusiastic people have a tendency to occasionally get ahead of the message. Such an event occurred in mid-October when the Small Business Administration (SBA), under the leadership of Administrator Erskine Bowles, released a publication entitled "The Health Security Act: Benefits to Business." This publication, apparently released to the public on September 28, indicated that an outside group comprising actuaries and economists had validated cost and savings projections. Of course, the bill had not yet been finalized at that time and the President

had yet to make final decisions, which meant that such a validation by outside experts would not have been possible. Ironically enough, in light of the later "Harry and Louise" ads, the publication also featured characters named "Charles" and "Danita and her husband" with illustrations of how much Americans would save under the Clinton plan. This was not lost on the Republicans in Congress. On October 18, 1993, 62 members of the House of Representatives, including Newt Gingrich, Dick Armey, Tom DeLay, Rick Santorum, Denny Hastert, and Duncan Hunter, sent a letter to the President requesting clarification of this and several other points in the SBA brochure (Hancock, et al., 1993). No response to the letter was uncovered in the files.

In mid-November, Senate Majority Leader Mitchell and House Majority Leader Gephardt introduced the administration's bill in their respective chambers. In preparation for high public and media interest in the bill, Chris Jennings sent a rough draft of non-technical changes to the bill (from its original October 27 version released by the White House) to the First Lady on November 19 (Jennings, 1993). That same week, the First Lady and Tipper Gore hosted a two-hour briefing on the Hill for spouses of members of Congress and Cabinet members (Blinder & Greenberg, 1993).

Almost as if baiting the Republican opposition, Senator Moynihan, Chairman of the powerful Committee on Finance, introduced legislation on November 3 to increase federal taxes on handgun ammunition. Increases from 11 percent to 50 percent on most handgun ammunition, plus a 10,000 percent tax on the Winchester 9-mm hollow tipped "black talon" bullets and all .50 caliber bullets were part of the legislation. What was most striking was that the Senator also announced that he planned to incorporate his legislation into the health care reform bill (Senate Committee on Finance, 1993). Moynihan was irritated with the President for wavering on welfare reform (H. Johnson &

Broder, 1997), and one might speculate that he proposed attaching the handgun ammo tax legislation to the President's health bill as a result.

On December 8, 1993, the White House sponsored a breakfast with House and Senate cosponsors of the Health Security Act in the Indian Treaty Room at the Old Executive Office Building. By that time, the bill had 101 House cosponsors (H.R. 3600) and 31 Senate cosponsors (S. 1757; Ricchetti, Verveer, Jennings, & Lew, 1993). The McDermott alternative bill (H.R. 1200) had 89 sponsors as of November 3 (Office of Congressman Jim McDermott, 1993).

The Lewin-VHI group, a leading private health care accounting and econometrics firm headquartered in Virginia, conducted an independent review of the Health Security Act and found it to be fully funded (Lewin-VHI, 1993). Based on the Lewin-VHI report, Alice Rivlin, Deputy Director of the Office of Management and Budget (and close friend of HHS Secretary Shalala), issued a statement saying, in part, that "[t]he study confirms that the Health Security Act is fully financed and that it will reduce the deficit over the period from 1995-2000" (Rivlin, 1993). The next day (December 9), Treasury Secretary Bentsen and OMB Director Leon Panetta held a press briefing in the White House Briefing Room to discuss the report in more detail. Bentsen was particularly pleased that the study's estimate of government subsidies required under the plan was less than the administration's estimates (White House Office of the Press Secretary, 1993b).

Within weeks, if not days, of the delivery of the actual bill to the Congress, the campaigns for and against the Clinton plan were in full swing. The media was not above sensationalizing the debate. A *Philadelphia Inquirer* article by Shaw (1993) reported that a number of biotech firms had halted or slowed development of promising treatments for a variety of diseases ranging from rheumatoid arthritis to breast cancer to AIDS as a result of fears that the new Clinton health care plan would create a market in which

development of these treatments would not be profitable. The article caught the eye of the President (W. J. Clinton, 1993a), who clipped a note to it asking Ira Magaziner whether there was "anything we can do about this." On January 6, 1994, some six weeks after the article had appeared in the Philadelphia newspaper, Magaziner and Jennings (1994) issued a five-page memo to the President outlining the relevant aspects of the plan and that there were certain "options…being reviewed by Administration and Congressional representatives that the biotech industry finds quite appealing" (p. 4). This is one of only a handful of indications of correspondence directly with the President in the Jennings files. What makes it extraordinary is the nature of the response. One cannot know for certain what the President (W. J. Clinton, 1993a) had in mind when he wrote the note to Magaziner. Knowing, as we do, that the President was a political man, considered by many to be one of the finest political minds of his generation, we can make an educated guess that the President's interest was less in what the Administration could do to appease the biotech industry than in what they could do about damaging stories. Magaziner, known to have been tapped by the President for his organizational skills and technical prowess, gives an answer framed in the terms with which he was most comfortable, i.e., how the bill could be technically changed to appease the biotech companies. This mismatch between a political President and the co-chair of the task force is illustrative of the myriad internal barriers to success that the Administration confronted.

In one example of many articles, interviews, and interpretations to come, an early February, 1994 *New Republic* article by McCaughey (1994b) emphasized such misleading notions as the government setting a national budget for health expenditures, every person being forced to buy only a government plan, a severe reduction in consumer-based choice of providers, and limited choices of insurance companies. The

article was sufficiently important to command an eleven-page rebuttal from White House Press Secretary Dee Dee Myers (White House Office of the Press Secretary, 1994).

The Clinton plan had its media champions as well. Michael Kinsley (1994), in a January 30, 1994 editorial responding to McCaughey's, said "[I]t is pointless to compare the Clinton plan with some idealized version of the classic American system, in which you can go to any doctor you want, who can perform any treatment he wants, order any test she wants, prescribe any drug he wants, and charge whatever she wants, all paid for by insurance. That system is disappearing, whatever we do" (p. D3). In hindsight, Kinsley may have been prophetic, but it was not that difficult a prophecy as so-called "patient choice" had been eroding rapidly since the passage of the HMO Act under Nixon in the early 1970s.

Legislative strategy was a hallmark of the Johnson Administration as documented in Chapter Five. I have hypothesized that one contributing factor to the Clinton failure was a lack of understanding of legislative strategy and the "inside ball" of Washington politics on the part of the Clintons and the young White House staff. It now occurs to me that this hypothesis assumes only a benign ignorance of the formulation of legislative strategy, while the truth may be that there was a more malignant lack of interest in the process. Johnson had the advantage of a landslide election. Clinton was elected by a plurality of the vote and not a majority. Johnson had a much stronger, filibuster-proof Senate base of Democrats and a larger base in the House as well (and he knew how to maintain party discipline). Clinton did not have a congressional background, and his party's majorities in Congress were slimmer than Johnson's making it arguably even more important for him to actively understand and pursue a workable legislative strategy.

Evidence of the lack of interest comes from a memo prepared by Assistant to the President for Legislative Affairs Pat Griffin (1994a) on Saturday, January 22. The memo

was, in essence, a briefing paper for the President and the First Lady for a meeting to be held on Monday, January 24, 1994 in the Oval Office with the President, First Lady, key White House staff, Speaker of the House Foley, and Senate Majority Leader Mitchell. A key to the President and the First Lady's lack of interest comes from the First Lady's schedule (Office of the First Lady, 1994, pp. 110-125). The President and the First Lady spent that weekend at Camp David, having left on the afternoon of Friday, January 21, the day before the memo was prepared. The meeting with the Speaker and the Majority Leader was held at 3:00 p.m. the following Monday, January 24. The First Lady's schedule indicates that the briefing for the meeting took place at 2:45 p.m., only 15 minutes before the actual meeting itself. This was the preparation for the legislative strategy meeting with the Congressional leadership!

As to the content of the legislative strategy memo (Griffin, 1994a) itself, a certain level of hubris on the administration's part can be read between its lines. Griffin envisioned a "reasonable timetable and strategy that, while somewhat flexible to currently unforeseen developments, serves to discipline the process" (p. 1). Griffin recognizes that the timetable, once agreed to by the President, the First Lady, Speaker Foley, and Majority Leader Mitchell, will have to be sold to the five committee chairmen who have control over the legislation. [A subsequent meeting with the participants of this first meeting and the five chairmen was held on February 3, 1994 (Griffin, 1994d; Office of the First Lady, 1994, p. 189)]. Unlike the adept LBJ and his staff, however, Griffin proposed that the Clintons adopt the stance that "it would be counterproductive for the Administration to be involved in the day to day actions/decisions of the Committees. This does not mean the Administration is not engaged in the work of the Committees; it does mean, however, that it is a role that is primarily technical and behind the scenes until later

in the process" (p. 3). Rarely, if ever, did Wilbur Mills hold a meeting on Medicare where Wilbur Cohen was not present representing the Johnson Administration's interests.

Finally, in a display of either hubris or an almost stunning naiveté, Griffin (1994a) proposes that the "optimal outcome from this proposal would be an agreement to establish a bicameral, Committee Chairmen coordination mechanism" (p. 3). This suggestion arises out of the perceived, and likely justified, fear of the House to be forced to go first and take a tough vote in an election year only to be "whip-sawed by the Senate [in a] repeat of what they feel they went through in last year's budget process" (p. 2). In other words, the House would be looking for cover, and Griffin feared that the absence of political cover would result in the House adopting a watered down version of the bill that would not meet the promises of universality and affordability the President and the First Lady laid out. Griffin's proposal to provide this cover was essentially to put in place a mechanism, not already envisioned under the rules of either chamber, to coordinate the timing of the legislative process. It is hard to imagine that anyone thought that the Administration would be in a place to impose, much less manage, such a mechanism (Griffin, 1994a). Apparently, however, this passed the muster of the first meeting (with the Speaker and the Majority Leader), as the briefing memo (Griffin, 1994d) for the second meeting (including the five chairmen) includes the same proposal.

Apparently, the chairmen agreed to the necessity for coordinated scheduling, though the implementation of a specific mechanism appears not to have been agreed to in the February 3 meeting, as indicated in a subsequent memo (Griffin, 1994b). Following the February 3 meeting, the nonpartisan Congressional Budget Office had issued its report on the Health Security Act, which Griffin (1994b) described as "potentially very damaging" (p. 1). A second meeting with the same group (including the five Chairmen) was scheduled for February 9. At this meeting, Griffin envisioned the President outlining

his minimum acceptable "bottom line provisions" (p. 2). Furthermore, this memo introduces Griffin's fear that the press was looking for signs of infighting among the Democrats and that the President should take advantage of the meeting to: a) request private airing of differences; and b) discuss whether the meeting itself might present a good opportunity for the President, First Lady, Leadership and Chairs to present a united picture to the press.

Meanwhile, trouble was also brewing in the form of the single-payer advocates who were co-sponsors of the McDermott alternative bill. Subsequent to a dinner with the President and Republican leaders, there was concern that the single-payer co-sponsors might view the administration as negotiating with the Republicans and cutting the single-payer co-sponsors out of the decision processes. Further concern was expressed over the change in language from "universal coverage to guaranteed private health care" (Griffin, 1994c, p. 1), a change that would concern the co-sponsors but could be allayed by emphasizing that the Clinton bill allowed states to choose a single-payer *option if they so chose*. A meeting was held in late February with the President, the Vice President, the First Lady, key White House staff, and eleven single-payer co-sponsors led by Jim McDermott for the purpose of allaying these fears (Griffin, 1994c).

McDermott's bill was not the only Democrat alternative being offered. Ted Kennedy, long a champion of health care, had also put forth a bill which proposed, among other things, that the Federal Employees Health Benefit Program (FEHBP) be used as the insurance vehicle to cover those not insured through a large group-sponsored plan and that the Office of Personnel Management (OPM) provide state-level contracting functions to facilitate the proposal. The Administration took the Kennedy proposal at least seriously enough for Chris Jennings to generate a memo to Ira N. Forman, Director of the OPM Office of Congressional Relations, concerning technical changes that would

need to be made to the Kennedy plan in order to ensure sufficient financing for OPM to carry out the proposed contracting functions (Jennings, 1994). The idea of opening up the FEHBP to segments of the uninsured or in the reform of Medicare continues to garner interest (Daschle, 2008; Merlis, 2003; The White House, 2009).

In addition to the McDermott and Kennedy bills, a group known as the Mainstream Coalition, led by liberal Republican Senator John Chafee (R-RI), was proposing its own legislation. Comprising about 20 senators from both sides of the aisle, the Mainstream Coalition proposed a more conservative approach to the problem including the absence of employer mandates. Attempts were made to resolve differences between the Mainstream Coalition plan and the Mitchell bill, including meetings between Mainstream staff, the Majority Leader's staff, and White House staff. On June 27, 1994, negotiations apparently proceeded around the clock with memoranda of proposed agreements appearing in the Jennings files at 3 a.m., 12:15 p.m., and 6 p.m. ("Mainstream Coalition Proposed Agreement, June 27, 1994, 3 a.m.," 1994; Mainstream Coalition Proposed Agreement, June 27, 1994, 6 p.m.," 1994; Mainstream Coalition Proposed Agreement, June 27, 1994, 12:15 p.m.," 1994).

These discussions continued during the August recess with Mainstream staff meeting with Mitchell's staff to identify areas of agreement and disagreement. The Mainstream plan would have called for a $250,000 cap on non-economic damages from malpractice claims (tort reform), while the Mitchell bill had no such cap. Additionally, the Mainstream bill called for increasing deductibility of premiums, eventually to full deductibility, for self-employed and individuals whose employers did not otherwise cover them, while the Mitchell bill offered 50 percent deductibility for self-employed and no deductibility for employed individuals whose employers did not provide group coverage. Finally, the Mitchell bill offered prescription drug coverage under Medicare while the

Mainstream Coalition objected to any non-means-tested coverage but proposed making commercial prescription plans available to seniors on a voluntary basis (Mainstream Coalition Staff, 1994). What is most important about the Mainstream Coalition is that it peeled off Democratic votes from direct support of the administration's Health Security Act.

In early July, the Administration was still concerned about the order in which the chambers would act. The previously expressed ideal was that the Senate would act first which would give the House political cover in the wake of the budget bill. If the Senate would move up to a universal coverage bill, the House would have the best possible political coverage, according to an analysis by Pat Griffin, Assistant to the President for Legislative Affairs (1994a). However, it would be "extremely unlikely to sustain a majority in the Senate" (p. 1). The House Democrats were unwilling to go too far out on a limb to pass a bill that the Senate would then either weaken greatly or fail to pass altogether.[9] Griffin was concerned that starting with too strong a package could result in a free fall to an unacceptable package since failure of the higher bill would undermine Mitchell and his proposal. On the other hand, if the White House tried to broker a deal between the administration, Senate, and House leadership, members on both left and right would likely perceive it as too much of a compromise which could also lead to failure.

Majority Leader Mitchell's bill (S. 2357) was introduced on August 9, 1994. On that same day, the Congressional Budget Office (CBO) sent Mitchell estimates of the effects of the proposed legislation on the budget. The CBO estimated that the Mitchell

[9] The House had already experienced this particularly painful lesson once. During the budget negotiations, the President had forced the BTU tax on energy on his own party claiming he would not sign the budget bill without it. The House passed the bill with the unpopular tax in it. However, when it got to the Senate, David Boren (D-OK) balked at the tax making its removal from the bill the price of his vote for the budget bill. Clinton caved and the BTU tax was dropped, but the House members had already gone on record voting for it. They did not want to be caught like this again (H. Johnson & Broder, 1997).

bill, with or without mandates, would achieve 95% coverage of the American public by 1997 with no increase in the federal deficit by the year 2000 (Reischauer, 1994).

In late August, the President met with a group of CEOs to discuss health care. During that meeting, he asked Letitia Chambers, a public policy consultant attending the meeting, for a memo outlining her ideas regarding streamlining health care reform by making the employer mandated coverage the actuarial equivalent of the Federal Employees Health Benefits Plan (FEHBP; Herman, 1994)[10]. The problem related to the wide variety of plans already in force in the marketplace. The President's original proposal would have called for a federally mandated minimum level of benefits. While many companies had plans that went well beyond the value of the minimum level proposal, they might not have certain particular benefits and would have to purchase these benefits and alter the plans accordingly, which would potentially increase both administrative costs and premiums. Business leaders were having difficulty with this aspect. Chambers proposed that the language be changed such that any existing employer plan for which the actuarial value of the benefit was equal to or greater than that of the Blue Cross/Blue Shield version of the FEHBP would be considered a certified plan (Chambers, 1994). Clinton apparently liked the approach well enough to pass it along with a handwritten note to Harold Ickes and Ira Magaziner (Herman, 1994). Ickes received the memo but did not pass it on to Magaziner until September 8, some fifteen days after it was received in the White House (Ickes, 1994).

[10] "Actuarial equivalence" is a method of comparing the value of the benefits provided by two different policies. The method incorporates the risk that a given covered expense will be incurred across the population. In this case, it was proposed as an alternative to a "minimum mandated benefits package." As long as the value of the benefits was actuarially equivalent they would not have to be identical in order to be certifiable under the legislation.

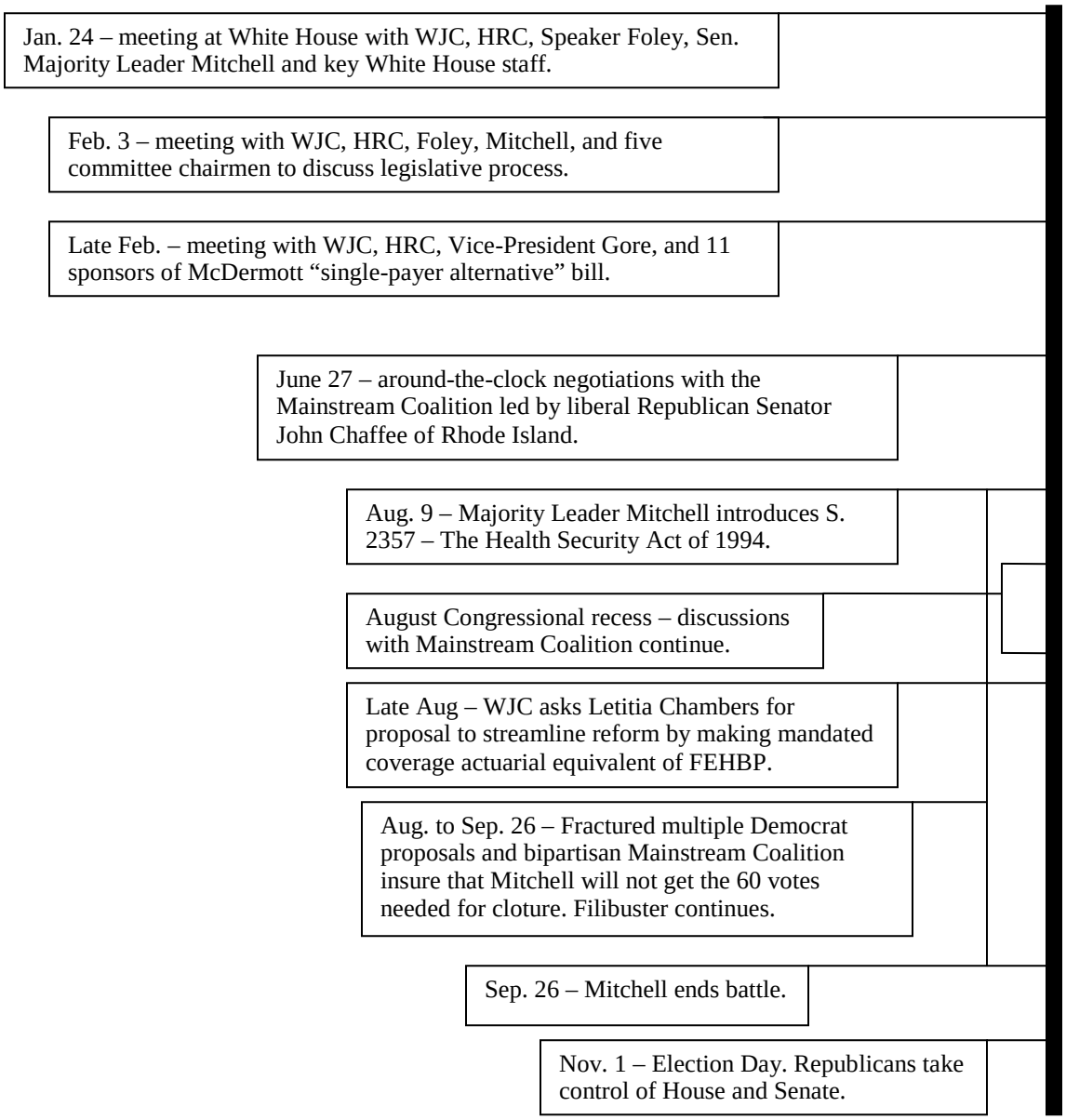


Figure 11: Timeline for January 1, 1994 to November 1, 1994

. In the end, it was the Senate that would be the initiative's downfall. Fractured multiple proposals from Democrats and the bipartisan Mainstream Coalition group insured that a filibuster of the bill would not be broken with a cloture vote requiring a supermajority of 60 senators. Finally, on September 26, 1994, Majority Leader Mitchell

ended the battle that Clinton had launched just over a year earlier in his address to Congress. Mitchell attributed the defeat to a combination of outside forces (insurance industry) and internal forces (majority of Republicans who opposed any sort of health care measure). The Health Security Act was dead. Six weeks later, with the defeat of the Health Security Act providing fodder for Newt Gingrich's Contract with America's anti-welfare and anti-big government crusade, Republicans gained the majority in the House of Representatives for the first time in 40 years (H. Johnson & Broder, 1997; Marmor, 2000; Quadagno, 2005; Skocpol, 1996). A timeline of the major events in 1994 appears in Figure 11.

NATIONAL HEALTH CARE REFORM AND THE PRESS

As noted in Chapter Five, McCombs' (2004, 2005) work is instructive in utilizing newspapers as markers of media attention during both Administrations. Media availability had virtually exploded between the Johnson and Clinton eras. Growth in cable market penetration, availability of 24-hour news channels, and the Internet made public access to news of the day much more prominent in the 1990s than it had been in the 1960s. However, newspaper coverage has been shown to mirror other media attention.

I initially searched the ProQuest Databases for *The New York Times* and *The Los Angeles Times* for the search words "Clinton" AND "health care" OR "Health Security Act" in the document text field of the records. I further specified a date range of January 20, 1993 (date of Clinton's inauguration) to September 26, 1994 (date that Majority Leader Mitchell pulled the plug on the Health Security Act). Between the two newspapers, a total of 5,853 articles met the search terms with 1,376 of these appearing on the front page (ProQuest Historical Newspapers The Los Angeles Times [1986-

present], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009).

The initial *New York Times* search yielded a total of 3,276 articles. Front page coverage comprised 405 articles over the time frame (ProQuest Historical Newspapers The New York Times [1851-2005], 2009). The same initial *Los Angeles Times* search yielded 2,577 articles; of these, 971 articles appeared on the front page of *The Los Angeles Times* (ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009).

After examining a number of articles, it became apparent that the search was including many articles which mentioned health care and the Clintons, but were not specifically about the health care reform effort. Subsequently, I reran the search, changing the second search term from "health care" to the more restrictive "health care reform." The results of these searches yielded a total of 2,308 articles: 984 from *The New York Times* and 1,324 from *The Los Angeles Times*. Of these, 646 articles—125 from the New York paper and 521 from the Los Angeles paper—appeared on the front page (ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009).

In an effort to determine the editorial position of the press during the Clinton era, I first refined the search on each of the two newspaper databases to reflect only those articles showing either a document type of "editorial" for *The New York Times* or appearing in the "opinion" section of *The Los Angeles Times*. This yielded a total of 110 documents for *The New York Times* (ProQuest Historical Newspapers The New York Times [1851-2005], 2009) and 51 articles in *The Los Angeles Times* (ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009). Search parameters for

document text and date remained the same as in the second (more restrictive) set of searches above.

I examined each of the editorial articles in both newspapers. Reading each editorial, I coded it according to whether the writer was endorsing the reform effort (positive), opposing it (negative), or included both positive and negative sentiments toward it (neutral or balanced). This examination revealed a relatively similar editorial position on the part of the two newspapers, with The Los Angeles Times showing a slightly more negative editorial slant on the issue. Overall combined results showed 26.7% (n=43) of editorial articles were positive toward reform, 16.8% (n=27) were negative toward reform, and 24.2% (n=39) were neutral or balanced on the issue. A combined 32.9% (n=53) were not directly related to the reform effort per se, but mentioned it in the context of addressing some other issue. Both papers were at least marginally more positive than negative about the reform bill. Together, the positive editorials outweighed the negative editorials by almost a 2-to-1 ratio (26.7 percent positive versus 16.8% negative). To the extent that this reflects the editorial bent of the totality of media covering the reform effort, it further illustrates the point that the valence of the media is far less important to outcomes than is the attention paid by the media. The editorial valence was not radically different between the two eras. If anything, the editorial position of *The Los Angeles Times* was more negative during the 1965 effort than during the 1994 effort. What did differ was the amount of attention paid to the issue, with far greater numbers of relevant newspaper articles appearing in the Clinton administration than the Johnson administration. This analysis will be further explored in Chapter Eight. Complete results of the Clinton media analysis appear in Table 2 below.

Table 2: Editorial Valence of *The New York Times* and *The Los Angeles Times*

	The New York Times		*The Los Angeles Times*		Combined Results	
	n	%	n	%	n	%
Positive	31	28.2%	12	23.5%	43	26.7%
Negative	17	15.5%	10	19.6%	27	16.8%
Neutral	24	21.8%	14	27.5%	38	24.2%
Not Directly Related	38	34.5%	15	29.4%	53	32.9%

NATIONAL HEALTH CARE AND THE GALLUP POLL'S MOST IMPORTANT PROBLEM QUESTION

Polling data regarding health care is much richer during the Clinton administration than it was during the Johnson administration; perhaps this is a reflection of the attention that the issue received in the press/media and among the public. Before looking at some of the other Gallup polling data available during that time frame, however, let us look again at the Gallup Organization's "Most Important Problem" question, i.e. "What do you think is the most important problem facing this country today?"

Prior to the general election in November of 1992, health care was relatively low on the nation's radar as a "most important problem." The poll ending March 29, 1992 showed that only 10.78 percent of respondents (174 of 1,610) listed health care as the most important problem, while 41.43 percent listed the economy in general as most important (The Gallup Organization, 1992a). By May, only 7.42 percent (297 of 4,007) listed health care with 28.54 percent listing the economy in general as the most important problem (The Gallup Organization, 1992b). By Labor Day, just two months ahead of the election, health care was back up slightly to 11.52 percent (400 of 3,473), with the economy at 36.9 percent (The Gallup Organization, 1992c).

The election occurred on November 3, 1992, and William Jefferson Clinton became the 42nd President of the United States on January 20, 1993. Just prior to the inauguration, Gallup reported that 18.44 percent of respondents had indicated that health care was the most important problem with 35.35 percent listing the economy in general (The Gallup Organization, 1993a). By September, just prior to the President's address to the joint session of Congress, health care had jumped slightly ahead of the economy in general with 27.9 percent listing health care and 26.22 percent listing the economy (The Gallup Organization, 1993b). Meanwhile, crime and violence had jumped from single digits in the earlier mentioned polls to 16.89 percent in the September, 1993 poll (The Gallup Organization, 1992a, 1992b, 1992c, 1993a, 1993b).

The public spotlight on health care continued to grow, peaking around 30.81 percent on the MIP poll by late January of 1994, a year into the Clinton administration. In that same poll, only 16.53 percent listed the economy in general as a problem, but crime/violence had jumped to 48.67 percent (The Gallup Organization, 1994c). By mid-summer, the public heat was a bit less intense with only 21.32 percent listing health care as the most important problem, 13.42 percent listing the economy in general, and 29.97 percent listing crime and violence (The Gallup Organization, 1994b). By mid-August, just a month later, health care was back up to just shy of 30 percent (29.49 percent), with the economy at 17.3 percent and crime/violence up to 52.38 percent. However, when asked whether they approved or disapproved of the way Bill Clinton was handling health care policy, 56.68 percent disapproved; only 35.26 percent approved (The Gallup Organization, 1994a). The health care debate was firmly in the public's sights. Not only were the media focused on the efforts, but the public was paying attention as well, ranking the problem high in importance. Unfortunately for the President, the spotlight was working against him rather than for him.

Congress was faring no better than the President. In the 1994 Labor Day Benchmark poll, Gallup found that 52.02 percent of respondents thought Congress had moved in the wrong direction on health care reform. This same poll, however, showed that a full 65.89 percent would support a health care reform package that guarantees every American private health insurance that can never be taken away (The Gallup Organization, 1994d). Clearly, the operative word was "private." By this time, the HIAA had aired the "Harry and Louise" commercials raising the specter of government-controlled health care limiting the choices of ordinary Americans. Finally, in the same Labor Day 1994 poll, 42.63 percent favored Congress passing minor health care reforms and continuing to work on major reforms in the next session, with only 19.76 percent favoring passage of a major comprehensive health care reform bill in the current session (The Gallup Organization, 1994d).

SUMMARY

Bill Clinton ran his campaign on fixing the economy. Five days after his inauguration in 1993, he put national health care reform on the front burner by naming his wife, First Lady Hillary Rodham Clinton, co-chair (with long-time friend from Oxford days Ira Magaziner) of the President's Task Force on National Health Reform. Though the Task Force was given 100 days to report back with legislation for the President to submit to Congress, it was not until nearly the end of 1993 that the Administration's bill was ready for delivery. This might easily be attributed to the fact that the Task Force grew from an initial projection of just under 100 persons to more than 600 people by the end of the hundred-day process, making the process extremely unwieldy.

Despite literally hundreds of meetings between the Task Force co-chairs and members of both houses of Congress, many of them with the First Lady present,

Congressional support was difficult to muster. Among Democrats, competing proposals combined with a skittish House of Representatives due to the handling of the budget bill made legislative strategy difficult. The House was still smarting over having the BTU (British Thermal Unit) energy tax rammed down their political throats by the administration only to have the President bail on the tax when Senator Boren demanded its removal from the budget bill as the price for his vote on the budget bill (H. Johnson & Broder, 1997). The Clintons had initially hoped to roll their health care reform package into the budget reconciliation bill, but Senator Robert Byrd refused to waive the "Byrd rule," which held that only budget items could be included in reconciliation bills (which were subject to automatic limits on debate rather than filibuster). In spite of that ruling, the Administration went ahead with its proposal, working closely with Majority Leader Mitchell.

Because the reform package was so broad, it touched, in major ways, on the authorities of at least five separate Senate and House committees, with at least minor interest from an additional nine committees. Attempts were considered to appoint an ad hoc committee to move the legislation to the floor more quickly, but both Senate and House leadership, including Speaker Foley, House Majority Leader Gephardt, and Senate Majority Leader Mitchell rejected these attempts (Quadagno, 2005; Skocpol, 1996).

The media spotlight was focused intently on the attempts to reform health care in the early 1990s, as evidenced by the extraordinary number of articles appearing in the press. Additionally, opinion polls indicate that the public was focused on the issue as well, likely a result of both news media attention and the public relations campaigns conservatives and their policy allies (e.g., health insurance industry) waged against the Clinton plan. In the end, the Senate was unable to invoke cloture and bring the bill to the floor. The public wanted reform—as late as August, 1994, 61.76 percent thought

Congress should pass a bill to reform the health care system—but the same poll showed that 47.79 percent opposed the plans proposed by Democratic Congressional party leaders, with only 38.7 percent favoring those plans (The Gallup Organization, 1994a).

To what extent would path-dependence theory have predicted the Clinton outcome? Again, we turn to Arthur's (1994) four principles: unpredictability, inflexibility, nonergodicity, and potential path inefficiency. The same early decisions about federal health policy that had set the path for Medicare were still in play in 1993. Since the passage and implementation of Medicare, a heightened emphasis on managed care had entered the path, as evidenced and reinforced by the Health Maintenance Organization Act of 1973 (P.L. 93-222) passed under President Nixon. Evidence that this turn had affected the path Clinton inherited can be found in the "managed competition" structure of the eventual legislation that Clinton and the Task Force proposed in late 1993.

Nearly 28 years had passed between the passage of Medicare and Clinton's first inauguration. This would mean that the path would be even more ingrained and inflexible. Americans had come to expect at least an illusion of patient choice, the loss of which was a fear on which the anti-reform parties capitalized in the national media and in paid advertising. The path also exhibited nonergodicity in that events that might normally be considered relatively "minor" or not having a direct impact on the outcomes did not cancel each other out. A good example of this is that the Clinton administration found itself saddled with a transparency requirement that was not present during the Johnson administration. The call for transparency was (and still is) ingrained in American public discourse, and it was codified in the Freedom of Information Act (P.L. 89-554). Ironically, it was President Johnson who signed that Act into law in 1966. Clinton's effort was directly impacted by the act as it formed at least a partial legal basis for the lawsuit

against the President's Task Force by the Association of American Physicians and Surgeons. This lawsuit forced the files of the Task Force to be opened to the public and ended First Lady Hillary Clinton's attendance at the Task Force meetings (H. R. Clinton, 2003; H. Johnson & Broder, 1997; Winfield, 1997).

As for potential path inefficiency, one could make the argument that no serious reform effort has emerged in the 14 years since the Clinton effort failed, attributable in part to a lack of Republican will to provide health insurance to most of the millions of uninsured, although the State Children's Health Insurance Plan (SCHIP) and Medicare Part D prescription drug coverage for Medicare beneficiaries have emerged. During the 2008 presidential campaign, a number of proposals for national health care were put forth. President Obama has requested $634 billion over the next 10 years to support such a program, though the specifics of his proposal are not yet clear. The Clinton failure can provide important lessons for Obama and his administration. Since it failed to materialize, its influence on the path was less direct. Expansion of the State Child Health Insurance Program (SCHIP) under President Clinton and the enactment of Medicare Part D prescription drug coverage under President George W. Bush have been relatively large incremental steps that are more likely than the Clinton plan to influence the path President Obama has inherited.

In spite of general public sentiment favoring reform, Republicans and outside opponents managed to stop it in its tracks. Along the way, they handed Bill Clinton and the Democratic Party a major defeat, and managed to deflect any blame for the failure onto the proponents themselves, resulting, at least in part, in the Republican takeover of both houses of Congress in the 1994 elections. I turn now to a comparison of the Johnson and Clinton attempts and the lessons to be drawn from them.

Chapter 8:
Lessons Learned

Having discussed the politics and history of federal health care policy, it is time to examine comparatively the paths, processes, and factors by which policy development and its ultimate success or failure materialized during the Johnson and Clinton administrations. My analysis focuses on the four orienting questions, previously outlined in Chapter One, and the three domains of path-dependence: historical, institutional, and political, discussed in Chapter Three. Many of the historical factors leading up to the Johnson effort as well as the factors occurring between the two administrations have been documented here and elsewhere. However, a comparison of the two presidents' efforts has been missing. A brief recap of the emerging themes regarding the differences between the Johnson and Clinton administrations sets the stage for a discussion of the lessons learned. I have taken the liberty of adding my understanding of the situation in the current, though very early, Obama administration:

- President Johnson assumed office in the wake of an immediate crisis and the face of ongoing domestic and geopolitical crises. President Clinton assumed office in a time of general peace. Crises are often the paths to policy change. President Obama has inherited a recession which is likely the worst since the Great Depression and he has said that the state of the economy rests largely on healthcare reform. Whether the current economic crisis will lead to major policy change in the healthcare arena remains to be seen;
- Johnson was elected in 1964 by a landslide majority. His electoral coattails were long, resulting in overwhelming majorities for the Democratic Party in both the House and the Senate. Clinton was elected with only a 43% plurality of the vote. While Democrats also controlled both houses of Congress, the margins were

considerably slimmer than under Johnson. Obama won with 53 percent of the vote, far less than Johnson, but a full 10 percent greater than Clinton. Democrats also increased their margins of majority in both houses of Congress. With the defection of former Republican Senator Arlen Specter to the Democratic Party, and should Al Franken be declared the winner of the contested Senate seat from Minnesota, Democrats will hold a 60-vote supermajority in the Senate (Lexington, 2009). The time may again be right, as it was when Johnson was president, for Democrats to see that health care reform is achieved;

- Johnson placed control of the administration's legislative agenda, especially regarding health care for the aged, in the hands of a small, select group of seasoned political operatives and career policymaking professionals. He then managed the process with close attention to detail. Clinton's Presidential Task Force on National Health care Reform, by contrast, had over 600 members before disbanding. There is no evidence in the archival documents to suggest that Bill Clinton paid anything like the same level of attention to the political process surrounding health care that Lyndon Baines Johnson paid. At just over 100 days into the new Obama administration, it is too early to tell how the new President will choose to run legislative operations out of the White House, but he might benefit from taking a lesson from the Johnson administration;
- Johnson maintained a high legislative tempo, flooding Congress with multiple, important legislative initiatives, preventing sustained focus on any one proposal over long periods of time. Clinton appears to have favored tackling one strategic goal at a time. So far, Obama has been very aggressive in getting Congress to pass multiple initiatives of a large nature, including his $787 billion stimulus package, an additional $350 billion in funds to rescue the financial sector of the economy

and a $3.4 trillion budget that includes $630 billion to help overhaul the nation's health care system, among others (Seib, 2009);

- Johnson put a relatively modest proposal (as compared to the final outcome) on the table and enabled key figures in Congress to take credit for beefing up the final legislation. He moved swiftly after the election to put the legislative wheels in motion. Clinton moved swiftly to announce his task force and to name First Lady Hillary Rodham Clinton and Ira Magaziner as co-chairs of it. However, the complex plan the task force delivered in its 1,000 plus page document was not sent to Congress until just before the end of the first session, a full 10 months after Clinton took office. It is too early to tell how President Obama will proceed. He has put forth a funding request, and Congress has agreed to it in principle, but he has yet to give any particulars of his anticipated process;
- The Vietnam War and the civil rights actions in the United States consumed most of the media attention during the Johnson administration. As a result, the public's attention, as evidenced by its responses to the Gallup Poll's Most Important Problem question, focused on these priorities rather than health care for the aged. This lack of a spotlight on Medicare relative to other issues facilitated the passage of the Medicare bill. Clinton's media world was considerably more complex than Johnson's with the advent of 24-hour cable news outlets and the Internet. As measured by newspaper coverage, the spotlight on health care reform was much more intense (than that on Medicare) and led to increased public attention on the matter and likely contributed to the failure of the initiative. It may well be impossible for Obama to avoid the spotlight on any health care initiative as health care has grown to be an even larger segment of the Gross Domestic Product. However, as business struggles to survive in the current economic crisis,

opportunities for the government to relieve business of the burdens of certain benefit plans, i.e., health insurance, in return for a fixed increase in payroll tax may become more attractive; and

- All members of President Johnson's healthcare administration team were men. First Lady Lady Bird Johnson played no public role in the passage of Medicare. Clinton named his wife to co-chair his task force. Hillary Rodham Clinton, a successful lawyer and public policy advocate prior to Bill's election to the presidency, became the public face of the Clinton health care initiative—a target for Republicans and their allies in opposing, and ultimately defeating, the Clinton plan. First Lady Michelle Obama has not been tapped for any major policy position in the Obama administration, at least during the first 100 days. Obama's team, however, does include some influential women. In the case of health care, it may be that the new Secretary of Health and Human Services (HHS), former Kansas governor Kathleen Sebelius, will play a prominent role. At this time, the Secretary has not yet named a permanent Administrator of the Centers for Medicare and Medicaid Services (CMS). In any event, President Obama might be well served to consider fielding a small, select team that includes a career policy professional from CMS or HHS to work with Congress on his health care legislation.

HISTORICAL FACTORS – ORIENTING QUESTION NUMBER ONE

The first orienting questions asks: a) what historical factors, including political, economic, and direct health policy components, set the stage for the respective success and failure of the Johnson and Clinton health care policy initiatives; b) were those factors natural, accidental, or planned; and c) in what sequence did they occur to facilitate the respective outcomes?

President Johnson took office as a result of the assassination of John F. Kennedy. Johnson had served in Congress from 1936 until he was elected to the Vice-Presidency in 1960. He had risen to power in the legislative branch, eventually serving as Majority Leader of the Senate. The historical evidence points to his effectiveness as Majority Leader, though his tactics to achieve success have received mixed reviews (Caro, 2002; Goodwin, 1991). Often portrayed as crude and boorish, employing high-pressure tactics to wrest support from reluctant congressmen and senators, his astute political mind and intense efforts to build consensus in much more refined ways has often been discounted. His knowledge of and relationships with the major legislative leaders of his day was critical to his extraordinary legislative success, not only with Medicare and Medicaid, but in the arenas of civil rights, voting rights, poverty policy, education, improved government, and job creation, to name but a few of his successful legislative initiatives.

When Johnson was elected President in his own right in 1964, he secured a landslide victory not only for himself, but for the Democratic Party in the Congress. With a filibuster-proof majority in the Senate and an overwhelming majority in the House of Representatives, he was poised to make legislative history as President. This began with his restructuring, with the cooperation of Senate and Congressional leadership, of the legislative committee system. This restructuring enabled Democrats to essentially overwhelm Republican opposition to the President's programs.

Furthermore, Medicare was hardly a new idea in 1964 and 1965. National health insurance proposals had been floated as early as 1908. President Franklin D. Roosevelt had initially intended to include it in the Social Security Act of 1935, but his advisors—among them social worker and Secretary of Labor Frances Perkins—dissuaded him from doing so because they feared losing the entire bill if the President overreached for medical care as well. President Truman had pushed, particularly after his election in

1948, for national health care. From 1948 until Johnson became President, every Congress saw some form of medical care for the elderly and indigent introduced, many of these by the Murray-Dingell-Wagner trio followed by the Forand legislation in 1958. In 1960, the Kerr-Mills Act was passed; it became the forerunner of the eventual Medicaid program—a means-tested, state-controlled, and partially federally funded medical assistance program for those living in poverty.

By the time Johnson took the Oval Office, most Americans who had health insurance coverage at all were covered by employer-provided commercial plans. This was an almost accidental outgrowth of wage and price controls during World War II. Since employers could not increase wages, the unions pressed for and employers agreed to provide fringe benefits, much of this in the form of medical insurance (Scofea, 1994a). A second reinforcing early decision in this vein occurred when the Treasury Department issued a ruling that such benefits, while deductible to the employer, were not wages and were therefore not reportable as taxable income to the employee. This practice, still enjoyed to the present day, resulted in a massive tax subsidy for employer-provided plans, lowering the cost of coverage provided in that system, increasing the attractiveness of the system to employers and employees alike, and, thereby, creating an increasing return to reinforce the growth of that system as the provider of choice for health insurance (Scofea, 1994a; Weathers, 2004).

A naturally occurring factor that facilitated the eventual successful passage of Medicare was that retirees were no longer contributing to the productivity of their pre-retirement employers, and were thus either cut from the rolls of the insured or were permitted to retain their employment-based coverage at a cost that soon began to overwhelm employers. As the population aged, this change in employer cost-benefit for retiree coverage became an increasing problem (Marmor, 2000; Oberlander, 1995).

Added to this were advances in modern medicine, many of which had come as a result of taxpayer supported research. These advances meant that seniors were living longer at a time when they had decreasing access to medical/hospital insurance coverage. These factors could hardly be called "planned," but they were far from "accidental" as well. Their convergence, however, was inevitable in the natural order of things, and this convergence resulted in increasing health care costs for employers, government, and individual Americans.

By 1965, the idea of a social insurance system was well-established in American culture. In fact, the Social Security system was 30 years old by that time. As a consequence, it was not an entirely new concept that people would pay into a system to insure themselves against the vicissitudes of medical necessity any more than it would seem strange that they would insure themselves against the ravages of old age or disability. Much of the infrastructure—through the Social Security Administration—was already in place for handling such an expansion. In this respect, Medicare and Medicaid might well be characterized as incremental policy changes, though the increment was certainly substantial. Still, Medicare's passage did not set aside the culture of employer-based coverage provided by multiple profit-seeking corporations and in a variety of available plans. The government was to be the insurer for older Americans and the poor, but these were people who: a) would not have had affordable access to commercially available insurance; b) in the case of retirees, included many who were either not covered or becoming a burden on the employer systems of care; and, c) as a result were not a desirable part of the commercial market. Government intervention was therefore not a major threat to the insurance industry.

By comparison, not only was Bill Clinton's election to the Presidency not a landslide; he did not even receive a majority of the popular vote, being elected instead by

a plurality of the vote. He had no “mandate” from the electorate and therefore had considerably less political capital than Johnson. Additionally, Clinton had never served in the Congress and therefore did not have the nearly thirty-year advantage of both knowledge of and relationships with the legislative players that Johnson enjoyed.

All of the historical factors surrounding employer-based systems of care and commercial for-profit insurers (e.g., tax-advantages for employer-provided benefits, negotiated contracts between insurers and providers, increased cost-shifting from employer to employee, treatment models instead of prevention models) continued, and in fact had become deeply entrenched in the culture of health care in the United States, post-Johnson. The intervening years had seen a rise in managed care operations, a path-dependent choice largely reinforced by President Nixon with the Health Maintenance Organizations Act of 1973. The idea behind managed care, of course, was to reduce the total costs for medical care through negotiations between insurers and providers as well as a system of utilization review designed to prevent overuse of unnecessary tests or procedures. It could be easily argued that managed care had failed to control the rising costs of medicine given that medical inflation during the period outpaced general inflation by a factor of three to one.

Bill Clinton had another major factor to deal with that Johnson did not have: Medicare itself. The introduction of government dollars into the medical system through Medicare, and to a lesser extent Medicaid, was a major factor in the rising medical care costs (Oberlander, 1995; Starr, 1995). Even the simplest economic model would predict that a growth rate in spending that exceeded the growth rate in services would result in increased prices. Add to this the oft-forgotten fact that it was eleven months from the signing of the Social Security Amendments of 1965 (which brought us Medicare and Medicaid) until Medicare was implemented. During that time, doctors and hospitals

scrambled to increase charges for services, since the bill implemented a system of payments based on the "usual, customary, and reasonable" charges for the specialty, procedure, and locale of services. This meant a decline in the amount of charity care being provided as such *pro bono* care would reduce average charges and therefore the amount that would be covered under the Medicare system. This factor alone accounted for an increase in medical inflation in the middle 1960s, an unintended consequence of the new programs.

In 1964, medical assistance for the aged was hardly a new idea. As previously stated, bills to offer such coverage in one form or another had been around since 1948. With the exception of the limited funds made available under Kerr-Mills, there had been no serious federal intervention in health/medical markets. The Kerr-Mills funds, furthermore, required matching funds from the states (which meant that poorer states were unable or unwilling to avail themselves of the Kerr-Mills funding), and participation required a state-administered means test, i.e., people had to prove they were too poor to afford care by any other means. This served to keep costs down. The Social Security Amendments of 1965 transformed Kerr-Mills into the current day Medicaid program, while Medicare expanded coverage to include virtually all persons over age 65 regardless of their means. As the population aged in the wake of decline in post-baby boom birth rates, more people became Medicare-eligible while the tax base to support the system faced serious decline with fewer younger workers to support Medicare through payroll taxes.

It could be argued that the government did not really understand how big Medicare would become. This argument would be strengthened by the fact that the major government economists were expressing concern only about the fiscal drag on the economy in 1966 and not beyond that point in time (Cohen, 1965j; O'Brien, 1965d;

Valenti, 1965a). Though the Johnson files contain multi-year projections, I found no evidence of any serious alarm being raised beyond the effects on the economy in fiscal year 1966.

Though there had been small incremental changes to the system between Johnson and Clinton, no attempt at a federal system of health insurance had gotten as far or garnered as much attention as Clinton's 1993 attempt. America's cultural heritage gave no indication that such a system would either be workable, or most importantly, desirable. The Cold War was not so far behind us that the idea of "socialism" was not still a very powerful archetype used to frame the argument against national health care. "Socialized medicine," which had also been used as a rallying cry against Medicare, reared its head again, this time pushing the idea that the government would decide what kind and amount of care individuals would receive and from whom and in what facilities they would receive that care (H. Johnson & Broder, 1997).

The irony is that the Clinton plan was far from socialized medicine. In fact, it might have had a better chance of success had the President and the First Lady embraced a true paradigmatic shift. Instead, the eventual plan was overly complicated, largely as a result of trying to maintain the culturally-ingrained concepts of employer-provided insurance and managed care/managed competition all within the private sector. Also thrown into the mix was the federalist idea of state-level control. This infused the process with myriad problems, not the least of which were rules under the Employee Retirement Income Security Act (ERISA; P.L. 93-406) that denied states the right to regulate fringe benefits and the problems that would arise when multi-state employers had to purchase coverage from different purchasing alliances in each state in which they had employees. Such an arrangement would mean that employees of multi-state employers might well end up with different benefits depending on the state in which they lived. One can only

imagine the havoc this would have wreaked with collective bargaining agreements between organized labor and these large corporations. A single-payer approach would have at least eliminated these obstacles.

PLANNING AND REACTING – ORIENTING QUESTION NUMBER TWO

The second orienting question asks: To what extent did the two presidents, their staffs, and legislators of the two time periods act to foment or facilitate these (historical) factors, and if not planned, in what ways did they react to or utilize these factors in pushing for passage of the respective presidential health care policy initiatives.

As previously discussed, Lyndon Johnson had been a Washington insider since 1936, intimately acquainted with the rules, the procedures, and the players in both House and Senate. It would be difficult, however, to say that he "planned" any of the historical factors leading up to passage of Medicare at least prior to 1964; to my knowledge, no one has suggested that he did. One could say that he actively worked to see that there was a liberal landslide, at least insofar as his own 1964 campaign had long coattails that helped Democrats expand their majorities in the Congress. Furthermore, it is well-documented that he planned the restructuring of the Ways and Means Committee in 1965 (Cohen & McComb, 1968; L. B. Johnson, 1971; Kearns, 1976; Mills, 1971). Traditionally, the Ways and Means Committee had a 2-to-1 ratio of majority party members to minority members. This would have resulted in 15 Democrats and 10 Republicans in the wake of the 1964 elections. Working closely with the President, Speaker McCormack restructured the committee to more accurately reflect the actual balance of seats in the House as a whole. This resulted in a 17-to-8 majority on the committee for the Democrats. More importantly, the new members were hand-selected to be supporters of the Medicare concept (Cohen & McComb, 1968; Marmor, 2000). Historically, Chairman Mills had been reluctant to bring any bill on any topic up for discussion or a vote if he did not feel it

had enough support to pass the Committee or, having passed the Committee, to pass the House. Johnson and McCormack solved that problem for the Chairman.

Johnson kept a good many of Kennedy's staff even after the 1964 elections. One key staffer that fit that bill was Larry O'Brien who managed legislative affairs for both presidents. Additionally, Johnson took the approach of surrounding himself with a small group of experts, empowering them to carry out his initiatives, and closely following up on his expectations of them. When one examines the White House Central Files related to Medicare and Medicaid, one does not see hundreds of people involved in the process. Only a limited number of people dealt with this issue in any depth on behalf of the administration. This core group included Wilbur Cohen, Larry O'Brien, Mike Manatos, Bill Moyers, and, to a lesser extent, Jack Valenti and Walter Jenkins. Even HEW Secretary Anthony Celebrezze, though copied on all of Wilbur Cohen's memoranda to the President or O'Brien, was not a major player in the negotiations. Johnson utilized a small group, and he kept each member within calling distance at all times. This is evidenced by notes written in the President's own hand on many of the memos and at least an initial "L" on many others indicating he had read them. This certainly speaks to the importance the President placed on the issue.

Though Johnson has often been accused of micromanaging his staff and bullying legislators—accusations that would certainly not be unfounded—it is interesting to see the subtle ways in which he also applied influence and power. Overall, he laid out the general scope for what he wanted accomplished and then tended to step back from the minutiae of the process until he was needed. This is not to say that he did not stay informed or involved. The prime example of this is in the final form that the Medicare bill took. The President's initial proposal was to cover hospital charges only. Republicans and the AMA actually put forth more comprehensive plans, but loaded them with

provisions that they felt would ensure the ultimate failure of their own proposals. When Chairman Mills realized that passage of the President's hospital-only coverage would disillusion seniors who thought the bill would cover their total medical expenses, only to find out it would cover on average perhaps 20 or 25 percent of those expenses, he approached the President about making the bill more comprehensive. Mills (1971, 1987a, 1987b) reported that the President essentially told him to do whatever he thought was best as long as he could get it passed.

As for how legislators may have planned or reacted to the factors, Mills himself orchestrated both the demise of the 1964 attempt and the eventual 1965 passage of Medicare. In the 1964 case, this largely came down to Mills honoring the request of fellow Democrats not to force them to vote on a bill that would be unpopular with many of their constituents while very popular with their elderly constituents. Had he forced a vote on the bill in 1964, the bill likely would not have passed, and the damage, especially to Democrats from southern states, might have meant a significant reduction in the size of the 1964 liberal landslide. With the President's long coattails in that election, Mills was ready to do business and promised to introduce Medicare if the President so desired. The word came back that this was precisely what the President desired.

In comparing the two Presidents, it is useful to look at the institutional domain, as outlined in Chapter Three. First, with respect to legislative tempo, it is well-known that LBJ was the most legislatively productive President in history to date. In addition to virtually flooding Congress with legislation, which meant that opponents had to fight on many fronts at one time, the President understood the value of moving swiftly once decisions were made – hence the phone call where he told Mills, Speaker McCormack, Majority Leader Albert, and others not to "let dead cats stand around on [their] porch" ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack,

Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). Johnson fully understood that delay gave the opposition time to marshal their forces.

Clinton, by comparison, seemed to prefer to tackle one thing at a time. Since the economy was a major concern of the public and had been the centerpiece of his campaign, he focused early efforts on the budget bill. Since Robert Byrd blocked him from rolling health care reform into the reconciliation bill, Clinton decided to put the health care bill on hold until the budget bill could be passed.

Where Johnson had had a handful of key advisors working on Medicare, the Clinton Task Force grew to more than 600 people representing Congressional committee staff, cabinet departments, White House staff, and industry representatives from the medical and insurance industries in particular as well as general business representatives. This effort to include everyone with an interest (and to attempt to incorporate all those interests into the final legislative proposal) sounds good on the surface. However, this massive cast of players resulted in a bill so complex as to be completely opaque to understanding by all but the most educated experts. In attempting to please all, the Clintons ended up pleasing none. This also meant long delays in getting the bill prepared for Congress. Indeed, when the President addressed Congress in late September of 1993, the bill was still not ready. A month later he and the First Lady attended a formal ceremony to deliver the bill to Congress, but it was another month still before the actual legislation was ready to be introduced. This meant that the bill would not be taken up until early 1994; and, 1994 was an election year. This played into the hands of Newt Gingrich and the Republicans who were looking to deliver a massive legislative defeat to the administration in order to facilitate a massive electoral defeat that fall. In this, they succeeded.

This aspect of the Clinton failure might provide an interesting future route for research utilizing the advocacy coalition framework. This framework holds the policy decision itself as the dependent variable while public positions of policy actors, types of actors, and policy venues are among the independent variables that are used to explain policy outcomes. The rise of these alternative policy subsystems or coalitions acting antagonistically shapes the ultimate decision (Sabatier & Jenkins-Smith, 1999; Schlager, 1999). In this case, the Task Force might be looked at as comprising a rather large set of subsystems itself. These actors then gave rise to a larger subsystem, the faces of which were the First Lady and ultimately the President. An antagonistic policy subsystem, in the form of Republicans and their conservative allies, then acted to restrict the success of the President's initiative. The advocacy coalition framework holds that it takes a decade or longer to produce significant change. An examination under this model, while beyond the scope of the original proposal, would certainly provide an alternative to exploring the Clinton failure.

Johnson was a master of positioning strategies. He knew well when to speak up and when to stay quiet. He understood the power of the bully pulpit that he had as President. He also was quick to share credit with as many as possible for victories, knowing that the public would credit him with them eventually. He also knew the power he had to reward legislators ranging from favors for their districts (such as decisions about military base closings) all the way down to photo opportunities with the popular President (Goodwin, 1991). Johnson also knew how to use the press to his advantage, even going so far as to put Harry Byrd on the spot in front of the press regarding raising Medicare in the Senate Finance Committee. (In doing so, he put Byrd in the unenviable position of having to either go along with the President or make a case in front of the press as to why he would not. He chose to go along with Johnson.) He also kept the press

guessing and was even known to change travel plans if they leaked out early to the press (Kearns, 1976).

Bill and Hillary Clinton, by comparison, did not have the personal knowledge and relationships that enabled Johnson to exercise his power and influence through the "Johnson treatment." Additionally, Clinton enjoyed being out front. For example, in late August of 1994, while the Mainstream Coalition was negotiating with Majority Leader Mitchell—negotiations being both encouraged and facilitated by White House staff—Clinton was making public statements criticizing the Mainstream plan for its lack of an employer mandate (Clymer, 1994). It is difficult to imagine Johnson doing such a thing. His style is evidenced by his handling of economists who expressed public concern about the fiscal drag of Medicare on the economy. He sent a handwritten note to Jack Valenti to "ask Ackley and Fowler to ask their friends to pipe down" (Valenti, 1965a). Johnson could have made a public criticism, but he undoubtedly knew that to do so would be to raise the stakes and give more exposure to the economists' concerns. Clinton apparently did not understand this concept, as evidenced by his public criticism of the Mainstream plan.

The two presidents' perceived level of engagement in their respective health care initiatives is less clear from the examination of the files. It is abundantly clear that Johnson was well-informed of what was going on legislatively with Medicare. Cohen's memoranda alone would support such a conclusion. To be fair to Clinton, the Johnson files are almost entirely open, it having been forty years since Johnson left office. Clinton's files are considerably less available. This limited my ability to reconstruct as complete a presidential record for Clinton in my analysis. This restricted availability largely arises out of two factors: passage of time and staff availability. The Presidential Records Act of 1978 (44 U.S.C. ¶ 2201-2207) requires that files be opened after twelve

years with certain exemptions. It has not yet been twelve years since Clinton left office. Additionally, the staff available to process the Clinton files are limited in number; therefore, fewer files have been processed in the eight years since Clinton left office. However, as Chris Jennings was the President's domestic policy adviser for health care, one could reasonably assume that most of the correspondence between, for example, the legislative staffs and the President would have passed through his hands. Only a handful of memoranda to or from the President appear in the Health Security Act (HSA) series of Jennings' files.

One exception to the disclosure rules covers confidential memoranda between the President and his advisors. Such correspondence is protected to encourage frankness in the advice given to a president. When a document is not released, a redaction record is placed in the file to show that the document has been redacted from the record available to the public. In the Jennings HSA series through September, 1994 (when Mitchell pulled the bill), only four memoranda to the President (listed as "POTUS" in the redaction records) have been redacted.

While it would be unfair to say that the written evidence shows that President Clinton was not as engaged as President Johnson, it is entirely fair to say that at least the Chris Jennings files do not support the engagement by President Clinton. Rather, it would tend to support the idea that the President delegated the responsibility to Mrs. Clinton and, for reasons that readers can conjecture for themselves, backed off from micromanaging the process.

Legislative priority is another dimension of the institutional domain. In the case of Medicare, Senator Anderson (D-AZ) and Congressman King (D-CA) both requested that their respective bills be given number one designations (S. 1 and H.R. 1 respectively) to denote the administration's priority with respect to the bills. It might be a stretch to say

that Medicare was President Johnson's top priority, but it would not be a stretch to say that it was a major priority. Johnson meant to see Congress pass all of his legislative agenda, and he was very successful in that respect. Medicare and Medicaid were certainly no exception. Indeed, the eventual bill, thanks to Wilbur Mills' "three-layer cake," encompassed far more than the President initially proposed. And, when Mills, McCormack, Albert, and Cohen called the President to tell him that the bill was to be reported out of the Committee on Ways and Means, there was a concomitant discussion about the start-up costs to general revenues to cover seniors who had never paid into the Medicare trust fund. These costs, which were substantial at the time, were estimated to be about $600 million. Johnson revealed to the callers that "by absolutely sitting on the Cabinet" he had managed to save close to a billion dollars below what he had gotten appropriated from the Congress. Therefore, the $600 million expense to general revenue was already covered by the President's own management efforts, evidence of Johnson's ability to plan for all contingencies ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). Johnson had pushed cabinet secretaries to control spending in their respective departments. In so doing, he had planned for the eventual startup expenses for Medicare, removing what would otherwise have been a potential stumbling block to passage. For comparison of the priority Clinton placed on his national health care reform effort, one need only look at the extended period of time it took to even deliver the bill to Capitol Hill.

Finally, outside factors and forces certainly influenced the outcomes of the two initiatives. In the Johnson case, it could be argued that the escalation of conflict in Vietnam was a critical, if indirect, factor in his success, for at least two reasons. First, Goldwater handed Johnson voters in the political center by going too far to the right on

the scare of communism. Johnson used Vietnam to show that he was not soft on the communists, having recognized that Goldwater was indeed handing him the political center (L. B. Johnson, 1971). Grubin (1991) suggests that Johnson orchestrated the Gulf of Tonkin incident in order to permit escalation of U.S. military activities. Whether that is true or not, Johnson certainly did use it to his advantage in the 1964 election. Perhaps even more directly, Vietnam consumed both the media and the public's attention during this period. Gallup polls in early 1965 showed that from 22 to 28 percent of the public saw Vietnam as the most important problem facing the country, while health care never rose above 1.26 percent in the same polls (The Gallup Organization, 1965a, 1965b, 1965c).

A second outside influence that indirectly kept the focus off of Medicare was the growing issue of race relations. In August of 1963, just over three months before Kennedy was assassinated, Martin Luther King, Jr. gave his famous "I Have a Dream" speech on the steps of the Lincoln Memorial as the culmination of the March on Washington for Jobs and Freedom. Racial tensions, particularly in the South, surrounding civil rights marches, Jim Crow laws, voting rights, and access to higher education were brewing. On the same Gallup polls referenced above, in which Medicare got less than 2 percent of responses to the "most important problem question," race relations garnered between 22 and 52 percent of the responses (The Gallup Organization, 1965a, 1965b, 1965c). The stakes to defeat Medicare were high for doctors (as represented by the AMA) and for Republicans standing for doctors and the insurance industry, but the public was not paying attention.

By comparison, the public paid extraordinary attention to Hillary Clinton and the Clinton Task Force and subsequent legislation. Bill Clinton had virtually assured that when he named his wife as co-chair of the Task Force. This is not to say that she was not

qualified. It is to say that he effectively painted a target on the back of his health care reform initiative in giving her such a prominent role. Indeed, this was the first time in the country's history that a First Lady had taken on a role as significant to national policy as Hillary Clinton's portfolio on national health care reform. Certainly, other First Ladies had been very active publicly; Eleanor Roosevelt and Lady Bird Johnson both come to mind. But none had ever, during their husbands' presidencies, headed a policy task force or initiative.[11] It should have come as no surprise that a prominent policy role for a First Lady would be met with some resistance. Rosalynn Carter had endured a great deal of criticism over the news that she had attended some of her President's cabinet meetings in the late 1970s, and Nancy Reagan was similarly excoriated for reports that she had consulted astrologers concerning policy decisions in the Reagan White House (Burden & Mughan, 1999; Carlson & August, 1992). Hillary Clinton's personality and tendency to wear business attire, combined with statements such as the comment about staying home and baking cookies made during the campaign, permitted her opponents to frame her as too masculine, too powerful, and too aggressive for a First Lady (Buckley Jr, 1993; Burden & Mughan, 1999; Carlson & August, 1992; Clift & Miller, 1992; H. R. Clinton, 2003)

While the specifics of the First Lady's role might not have been determined during the campaign, there certainly were hints that she and her husband intended for her to have a significant role in the event of his successful campaign for the presidency. Clinton was reported to have spoken of possibly appointing Hillary to the Cabinet

[11] I exclude Edith Galt Wilson from this analysis on the grounds that her critical role following Woodrow Wilson's stroke was surreptitious. Historians have alleged that she effectively usurped the power of the Presidency by making decisions in her husband's stead. However, her role as such was not known widely at the time and certainly not to the general public. By contrast, Mrs. Clinton's role was, at the risk of understatement, one of high visibility.

(Carlson & August, 1992),[12] and both of them were overheard to refer to Bill's election as either "buy one, get one free" (Carlson & August, 1992, p. 40) or "vote one, get one free" (Deacon & Mackenzie, 1993, p. 39). By the start of Clinton's second term, the White House press office was quick to disavow any policy role for the First Lady, but this was two years after health care reform had failed (Schorr, 1997).

. Hillary Clinton's entrance to the White House was not her first brush with national notoriety. Her commencement address to her 1969 Wellesley class was reported in *Life Magazine* (Cooper & Gest, 1992). She is a lawyer in her own right having graduated Yale Law in 1973 (H. R. Clinton, 2003), and just a year after her graduation, she served a summer on the 1974 House Judiciary Committee which was considering impeachment charges against President Richard Nixon at the time (Bruning, 1996; Cooper & Gest, 1992). She had an active legal practice with the prominent Rose Law Firm in Little Rock, where she reportedly made $160,000 per year in salary compared to her then-governor husband's $35,000 salary (Deacon & Mackenzie, 1993). She was widely criticized for an alleged disdain—perhaps overblown in the press—for women who had not chosen the same careerist track that she had, epitomized in her remarks that she could have "stayed home and baked cookies and had teas" (Burden & Mughan, 1999, p. 238; Cooper & Gest, 1992, p. 30).

When the Clinton's moved into the White House on January 20, 1993, it quickly became apparent that Hillary intended to participate in governance at least in terms of being a close advisor to the President. This was signaled early when she became the only First Lady to have an office in the West Wing. She also maintained the traditional office

12 Such an appointment would, in fact, be illegal under 5 USC IIIB 31 §3110 which prohibits the appointment by public officials of their relatives including spouses. This law was passed in 1967 primarily in response to John F. Kennedy's appointment of his brother Robert Kennedy as Attorney General ("5 USC IIIB Chaper 31 §3110. Employment of relatives; restrictions," 1967).

of the First Lady in the East Wing of the White House (Burden & Mughan, 1999; Deacon & Mackenzie, 1993). This prompted the late conservative libertarian commentator William F. Buckley, Jr. (1993) to refer to Hillary Clinton as "a woman who does not hesitate to act as chief of staff for her husband" (p. 70).

Hillary Clinton had a reputation for ruthlessness in her dealings with counterparties and even with her own staff. This was reinforced by her involvement in the travel office scandal that became known as Travelgate (Burden & Mughan, 1999). Accustomed to getting her way, many viewed her, rightly or wrongly, as too aggressive. She certainly did not fit the public's archetype of a First Lady. This resulted in a cognitive dissonance that was reflected in the media's coverage. Winfield (1997) said it this way, "The extent of her public power appears unprecedented, yet it is difficult to explain as a first lady news story, except negatively" (p. 243). Her relationship with the press was further damaged by her preference for secrecy during Health Care Task Force deliberations, a factor that prompted the lawsuit against the administration by the Association of American Physicians and Surgeons which resulted in a December 1993 ruling that the task force had withheld documents in violation of federal law (Winfield, 1997).

During her last year as First Lady, she successfully ran for Senate representing the state of New York. She was re-elected to that seat in 2006. In 2007, she announced her candidacy for the Democratic nomination for President of the United States. Initially considered the favorite to land the nomination, she was outmaneuvered by Barack Obama who went on to capture not only the nomination but the presidency. He subsequently named Hillary Clinton as his Secretary of State, a post she holds currently. This is a strong woman by any definition, and one who has never shied away from either the spotlight or controversy.

Whether Hillary Clinton envisioned running for President (or even the Senate) at the time she was running the Clinton health care reform efforts is not clear. In the event that she was entertaining such ambitions, it is a matter for speculation as to whether success with the health care reform initiative might have changed the outcome of the 2008 presidential elections. Had she and Bill been successful at passing the Health Security Act, her chances of being elected to the presidency in 2008 might have been enhanced, but this would have depended on the ultimate outcomes that the plan produced in the intervening years. What can be said with certainty is that such ambitions, to the extent they were perceived by the opposition party, would have raised the stakes providing ample incentive for Republicans to defeat the proposal.

By defeating the plan, Republicans handed the President a defeat in which he had a personal stake as well as a political one. As it played out, they did not even have to cast a vote against the Clinton plan. It simply died a whimpering death by filibuster. The timing could not have been worse. Mitchell pulled the plug on September 26, 1994, just 36 days before the mid-term elections that would put Gingrich in the Speaker's chair as his Contract for America denounced big government—and government does not get any bigger than a national health care program—and put Republicans in charge of the House for the first time in 40 years.

This brings us to the third question relating to the barriers to passage of national health care in the early 1990s and what could have been done to overcome those barriers. The bulk of this analysis rests in the political domain.

BARRIERS AND STRATEGIES – ORIENTING QUESTION NUMBER THREE

The public does not always get what it wants. Generally, public opinion acts less as a catalyst for action and almost exclusively as a constraint on legislative or executive action (Hofferbert, 1986; Mazmanian & Sabatier, 1980). The press—electronic and

print—mediates the setting of the public agenda through its editorial process in selecting what gets covered, how prominent that coverage is, how extensive it is, and how it gets reported (McCombs, 2004, 2005). How the press frames a given initiative can certainly be influenced by how public figures speak about that initiative, and there is no more influential speaker on the planet than the President of the United States. It is accepted that the framing of the debate can be more important than the actual arguments themselves, and Republicans are so keenly aware of this as to have spent considerable sums to study and determine exactly how any given debate must be framed for success (Hacker, 1997; Hacker & Pierson, 2005; Lakoff, 2004, 2006). For example, during the Johnson administration, Medicare was sometimes framed as "socialized medicine," but trying to go to the far right on Johnson proved to be disastrous for the Republicans, especially for Barry Goldwater. During the Clinton initiative, Republicans also frequently framed the Clinton plan as "socialized medicine." Both Republicans as well as their political allies (such as the health insurance industry) framed the debate as a (false) dichotomy over patient choice versus government deciding what treatment the patient will receive.[13]

As Johnson worked to pass Medicare, the press was paying relatively little attention compared to the focus during the Clinton attempt at national health care reform. Examination of newspaper databases covering *The New York Times* and *The Los Angeles Times* for the two periods is quite revealing. Between November 4, 1964 (day after the election) and July 28, 1965 (passage of the Social Security Amendments of 1965 by the Senate), a total of 145 articles containing the words "health care" and "aged" or "medicare" appeared in the two papers, and of these only 18 appeared on the front page of one or the other newspaper. In comparison, between January 20, 1993 (Clinton's

[13] I call this a false dichotomy because patients have very little choice under the present system. The difference is that instead of government making treatment decisions, insurers make them based on their profit profiles. In any event, those who have no health insurance have even less of a choice of treatment.

inauguration) and September 26, 1994 (date Mitchell pulled the bill) there was a stunning total of 5,853 articles containing the terms “Clinton” and “health care” or “Health Security Act,” more than 40 times the number of articles in the 1960s. Of those 5,853 articles, an equally stunning 1,376 appeared on the front page of one of the two newspapers (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009; ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009).

How does this compare with public attention to the issue? I point the reader again to the “Most Important Problem” question asked by the Gallup organization. For the polls I reviewed in the relevant time frames, the 1964-65 polls showed responses relevant to Medicare or health care for the aged in the range of 0.37 percent to 2.51 percent. Over the same time period, 6.19 to 28.71 percent of respondents listed Vietnam as the most important problem (The Gallup Organization, 1964g, 1965a, 1965b, 1965c). (The 6.19 percent was on October 13, 1964, less than two months after the Gulf of Tonkin Resolution was passed.) Over the same time period, “Vietnam” appeared in a total of 8,700 articles between the two newspapers (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009).

Relating press focus to public attention for the Clinton era, I recall for the reader that while 5,853 articles appeared in either *The New York Times* or *The Los Angeles Times* related to the national health care reform attempt (ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009), 18.44 to 30.81 of responses listed health care as the most important problem in the Gallup polls of the same time frame (The Gallup Organization, 1993a, 1993b, 1994b, 1994c). While one cannot draw a causal inference

between media coverage and public focus from these figures, they are highly suggestive of a correlation between public attention and press attention on the subjects. The extent to which the press influences the public and the public influences the press is difficult to say. Likely, the influences are reciprocal. However, since the press has the advantage of communicative and collective power over that enjoyed by the individual, it would not be unreasonable to presume that press attention would be the stronger influence.

As for the relationship between the media attention and legislative outcomes, it is somewhat remarkable that newspaper coverage prior to the Clinton failure was 40 times greater (as measured by the two newspapers used as markers) than the newspaper coverage prior to the successful Johnson initiative. I contend that this intense media spotlight and scrutiny served to raise the stakes for the opposition party to defeat the legislative initiative. Information availability increased exponentially between the Johnson and Clinton administrations with much broader cable access, advent of 24-hour news programming, conservative talk radio, and the rise of the public Internet. Media coverage of issues continues to expand. If my contention regarding intensity of the media spotlight is correct, then this expansion could have a chilling effect on future attempts, at least in terms of raising the stakes for the opposition party. Finding common ground will become even more important at the same time that it is becoming more difficult, particularly in view of the current partisan political divide in America.

As to how the Clinton administration and other interested supporters might have overcome these barriers, it would seem that better framing the debate would have been appropriate at the least. Permitting the opposition to frame the plan as “socialized medicine,” and as “limiting patient and provider choice,” with very little or at least ineffective challenge proved disastrous. The “Harry and Louise” ads alone provided political cover (i.e., gave the public reason to fear a government takeover of health care

under the Clinton plan) to Republican efforts to block the legislation. The Administration claimed large numbers of supporters among big business, small business associations, and professional associations like the NASW. Yet, none of these organizations funded memorable public relations campaigns in support of the Task Force initiative.

The administration also suffered from the inexperience at the national level of its leader, Bill Clinton. The staff was young and equally inexperienced. The Clinton administration lacked the power that Johnson had to discipline and to manage at least his own party members in the legislative branch. The selection of Ira Magaziner, who had a failed record as a business consultant and frequently admitted to lacking any understanding of the political process (H. Johnson & Broder, 1997), as co-chair of the Task Force, is illustrative of the level of incompetence. Simply put, LBJ had Wilbur Cohen. Bill Clinton had Ira Magaziner. Clinton either did not understand, did not fully appreciate, or simply lacked the ability to bring experienced hands aboard and to manage them in a tightly held circle of power with himself at the center. Had he done so, he might have been successful.

LBJ had an even bigger Wilbur in his arsenal as well: Wilbur Mills. The powerful Chairman of the House Committee on Ways and Means was as good at Washington's brand of "inside baseball" as they come. Far from engaging in a battle with the opposition (Republicans and AMA), Mills took their proposals apart, folded the parts he liked best into his own bill, and created the "three-layer cake" of Medicare Part A, Medicare Part B, and Medicaid. This not only improved the final bill in a way that would be a major asset in the next election cycle, but it made it very nearly impossible for the opposition to vote against the final bill, at least in Committee and for many of the opposition in the House as well. Clinton needed an ally on the inside as shrewd as Mills. It does not appear that he had any such allies in the Congress. He wanted to stake a big and early victory with

health care, but his ambition may have gotten the better of him. Rather than wait and build good will, he initiated the process too soon, still had to wait, and even then, his proposal was ultimately defeated.

Johnson did not write the final Medicare bill. In fact, his original bill would only have covered what eventually came to be known as Medicare Part A, i.e., hospital-only coverage. When Mills proposed expanding that to include physician fees as well, in an attempt to avoid disillusioning the elderly members of the electorate, Johnson told him to put it together however he wanted it. Whether Johnson knew that Mills (and Abe Ribicoff) would expand his vision is not known. That he was willing to allow others to do the heavy lifting and then to share the credit is well-documented (Goodwin, 1991; Gordon, 1965; Johnson's Special Message to Congress Outlining Broad National Health Program," 1965; L. B. Johnson, 1965c, 1965d, 1971; Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965). Johnson had a clear understanding that when he was sharing the credit around, everyone could see that it was *he* who was doing the sharing. Clinton, by contrast, fielded a 600-plus member task force, sought input from industry groups, social welfare organizations, organized labor, physician groups, and others before submitting a 1,000-page plus plan almost a year after starting the process.[14] His plan was complicated by the need to not upset the special interests in the “Turkish bazaar” we have inherited as a health care system. Clinton may have been more charismatic and more eloquent than Johnson. He fancied

[14] In a 2009 interview with Dr. Sanjay Gupta on Larry King Live, Clinton revealed that he would have preferred that Congress write the legislation, but that then-Chairman of the House Ways and Means Committee Dan Rostenkowski (D-IL) told him he would prefer that the administration provide the legislation and then the committee and Congress could amend it (Hirzel, 2009). I have not previously come across this information in other accounts of the period. This point would be worth following up. Perhaps when the oral history interviews being collected and processed at the University of Virginia Miller Center are completed and released, we may find more information on that aspect of the process.

himself as the successor of John F. Kennedy. It is worth remembering that Kennedy was unable to pass Medicare. Johnson, the less eloquent Texan, knew how to work his contacts, which were myriad, and how to apply power in the background without ever having to seek the spotlight himself.

In the case of Johnson and Medicare, one cannot deny that this was a massive step forward for the health care of the elderly. Yet, it was still an incremental step forward. The culture demanded then, as it does now, that only the deserving receive help. In order to "deserve" Medicare, elders have to pre-pay during their working years to insure their access to health insurance and health care in their retirement years. The poor must meet stringent means tests administered at the state level in order to receive Medicaid benefits. Johnson was even concerned that the deductibles and co-pays be high enough to "keep down the hypochondriacs" ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965), reflecting the insurance culture as it was then and continues to be today, i.e., a propensity to cut costs by eliminating coverage for first-dollar benefits which discourages preventive care.

When Bill Clinton became president, nearly 30 years had passed since Medicare and Medicaid became law. Because health care insurance and service provision remained rooted in the private sector in spite of the large public Medicare and Medicaid programs, Clinton was perhaps even more culture-bound than was Johnson. Clinton's managed competition approach was deeply rooted in the managed care concepts that Edgar Kaiser and others had promoted and which President Nixon had strengthened by signing legislation twenty years earlier. The plan attempted to incorporate the employer-provided system along with purchasing alliances on a state-by-state basis to attempt to encourage competition and control costs. Subsidies for the uninsured would have been based on

means tests tied to income as a percentage of the federal poverty level. None of this was based in any truly new conception of how health care ought to be delivered. Rather, it devolved into a complicated, if not convoluted, attempt to preserve the status quo of a profit-based negotiated delivery system while attempting to cover more of the population.

Perhaps Arthur (1994) is correct from an economic modeling perspective that early decisions have a tendency to become locked into a system. Perhaps he is correct that increasing returns accrue to lock the path in the direction first determined by those early decisions. However, it seems that at some point those economic constraints resolve themselves into culture and tradition and a sense of "how things are supposed to work" in a society. The United States is the only developed nation on the planet that does not have universal health care. It spends more per capita than any other nation, yet its health outcomes are far from the best. Apparently citizens of other countries just accept the idea that they can go to the doctor or a hospital and "the government" (i.e., their taxes) will cover the tab. That is how their systems were designed. It is their tradition and their culture. They truly cannot imagine anything different; the idea that health care would be denied to them because they cannot afford to pay it is unthinkable.

There is an old parable about a little girl asking her mother why she always cut the legs and wings off of the turkey before she baked it. Her mother referred her to her grandmother since that is where she first learned to do it that way. Her grandmother passed her on to her great-grandmother, as that is who had first taught her the magic of cooking the turkey with its wings and legs removed. When the little girl asked her great-grandmother why they always cut the legs and wings off the turkey before they baked it, great-grandma replied, "I don't know why these people are doing it. I did it because I didn't have a pan that was big enough to hold the bird."

Here in the United States, we still cut the legs and wings off the turkey because that is what mama and grandmother and great-grandma all did. We have forgotten that great-grandma did it because her pan was too small for the turkey. It is how we have always done it. As much as citizens of other countries could not imagine paying a deductible or a co-payment for medical care, much less being turned away for lack of ability to pay, Americans cannot imagine a system that is designed to take care of every person. This is what we mean by a "culture." Americans will come closer to achieving health insurance for everyone when the culture changes and agreement is reached on the philosophical underpinnings for the type of society we want. We cannot afford to do health care "the way we always have." The economics are simply unsustainable (Daschle, 2008; Herzlinger, 2007; Kotlikoff, 2007).

LIMITATIONS AND ADVICE FOR FUTURE SCHOLARS

In this study, I have relied on existing published accounts covering the two presidential administrations and their efforts to change health care. Largely due to feasibility restraints, specifically time and money, I elected not to conduct interviews of participants. In the case of the Johnson administration, many of the officials of that time are now deceased. However, a rich collection of oral history interviews is available in the LBJ Library, and I availed myself of these quite freely. A similar oral history project is underway for the Clinton administration under the aegis of the University of Virginia Miller Center for Public Affairs. As of this date, those interviews have not been released and will not be released until the interview process is completed some years from now.

The records of the Clinton administration remain largely inaccessible even eight years after the administration ended. This is a function of (1) the rules under the Presidential Records Act of 1978 (44 U.S.C. § 2001-2207) and Executive Orders 12667, 13233, and 13489 which govern the release of presidential records, and (2) the limitations

of staff time required to process records for release. As further records become available, the findings of this study may well be altered. Additional archival records may also be available, particularly at the Social Security Administration archives in Baltimore, Maryland, which may shed light on these legislative processes. Future scholars may also wish to examine the archives of legislators with a specific interest or role in these two health care reform efforts.

Since I began this dissertation 12 years after the failure of the Clinton effort, memories of participants are likely to be clouded by time. Alicia Shepard (2006, personal communication), who has published her findings from archival studies of the Woodward and Bernstein papers on Watergate housed at the University of Texas at Austin, further advised me that interviews with those specifically engaged at the time were likely to reflect not only the time-clouded memories of those persons but to have been revised, intentionally or unintentionally, to put the participants and their allies in the best possible light. Therefore, these would be of limited historical value in considering the path and processes of the two eras. Instead, I have relied on the records to speak for them.

Dissertations are, by nature, usually the work of a single individual. As such, and particularly in the case of qualitative analyses, they are subject to interpretive bias. I have addressed my biases elsewhere in the document. Future scholars would benefit from having multiple people code the documents to provide additional rigor in the analysis. To counter that problem, I have attempted to use the published interpretations of other scholars to triangulate my own findings throughout this study.

Chapter 9:
The Road to Somewhere

Not much has changed in terms of the American health care delivery system in the wake of the Clinton failure. With two exceptions, Medicare Part D and the State Children's Health Insurance Program (SCHIP; passed as part of the Balanced Budget Act of 1997: P.L. 111-251), Americans have not had a major addition to the government run programs. Congress has tweaked the SCHIP program to cover more children, and has recently passed a long-needed expansion to that valuable program. The other thing that has changed is that there are more uninsured citizens today than in 1994. In 2009, medical costs are projected to account for 17.6 percent of Gross Domestic Product (GDP), perhaps even more in the wake of the current economic and financial crisis and recession. The Centers for Medicare and Medicaid Services project that it will climb to 20.3 percent of GDP, an outlay of $4.4 trillion, by 2018 (Sisko, et al., 2009). The last government report actually shows a small decline in the number and percentage of uninsured (DeNavas-Walt, et al., 2008), but that may be a result of more people falling into income brackets that make them eligible for Medicaid as well as more retirees coming to Medicare age (Sisko, et al., 2009).

To be fair, the George W. Bush Administration and the then-Republican-controlled Congress did pass the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173), which instituted Medicare Part D, a federal program to subsidize prescription costs for Medicare beneficiaries. To be equally fair, the program has a large gap in coverage, commonly referred to as the "donut hole," which kicks in after the first $2,400 of expense, leaving about $3,600 to be paid by the insured before catastrophic coverage begins paying for prescription drugs again (Families USA,

2007a, 2007b). Once again, culture prevailed: this program is administered through the private sector.

Furthermore, the act specifically prohibits the federal government from negotiating prescription drug prices under the program. Consequentially, a study by non-profit health care consumer advocacy group Families USA (2007b) found that, for the twenty most commonly prescribed drugs, seniors covered under Medicare Part D paid a median difference of 58 percent more than those covered by Veterans Administration plans. The Veterans Administration is permitted to, and does, negotiate prescription drug prices on behalf of its members. A later report by Families USA (2007a) found that, for the fifteen drugs most commonly prescribed to seniors, the price had risen by a median of 9.2 percent from April 2006 to April 2007, during a time when the January 2007 Social Security Cost of Living Adjustment (COLA) was a mere 3.3 percent.

The reader can draw the conclusion as to whether the program is more help to seniors or more hindrance when weighing the benefits received against what Hacker and Pierson (2005) call "coverage that…has the dubious distinction of being at once stingy and costly" (p. 86). Certainly, many seniors who take medications and would otherwise have no prescription coverage have benefited from Medicare Part D. Had the Congress not restricted the program administrators from negotiating price with the pharmaceutical companies, the same benefits could have been provided at substantially lower cost to the federal government, and by definition the taxpayers who fund the government. In the more desirable alternative, the savings from negotiated pricing could have been used to reduce, and perhaps eliminate, the "donut hole" in coverage. Additionally, since the prices would clearly have been lower, based on the experience of the Veterans Administration, the initial coverage limits would have covered even more of the total prescription costs of each insured senior.

Such a change might have doomed the plan to failure, i.e., it never would have passed. The prohibition against government negotiating prescription prices amounts to a huge subsidy to the drug companies. After all, it was President George W. Bush and a Republican-controlled Congress who enacted Part D. These are the same people who fomented the current fiscal crisis through utter disregard for regulatory obligations of the government, outsourcing to no-bid contractors, and a host of other means of pushing public funds into private pockets in what Galbraith (2008) calls "The Predator State."

PROJECTIONS OF THE PATH FORWARD

Path-dependence theory suggests that major policy shifts occur only at critical junctures (Arthur, 1994). Findings in this study support the theoretical position. President Johnson took office in the wake of a national crisis—the assassination of President Kennedy. He also faced mounting national unrest surrounding both the civil rights movement and the Vietnam War. President Clinton faced no such crises. Johnson succeeded in passing Medicare and Medicaid; Clinton failed at the national health care reform effort. President Obama has stepped into the Oval Office at a point of severe economic crisis; a recession that may be the worst since the Great Depression (Puzzanghera & Oneal, 2009; Reckard, 2009). Obama's proposed budget outline calls for more than $600 billion in additional spending to decrease the health insurance coverage gap, though he has not yet outlined a specific plan for achieving this goal. Congress, meanwhile, is considering changing the favorable tax treatment of employer-sponsored medical plans to tax at least some portion of those benefits. Organized labor opposes any such change (Levey, 2009).

The treatment model of health care delivery, as opposed to a preventive model, will be much more difficult to change. The historical path clearly suggests that the treatment model has become embedded in American culture. Even the major changes

brought about under Medicare and Medicaid did not move the culture away from this model, as evidenced by the continuation of deductibles and co-payments in government plans, just as under private and employer-sponsored plans, in an effort to hold down costs attributable to “hypochondria” or “moral hazard” ("Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141," 1965).

If the culture shifted at all with regards to medical care, it likely came in the form of increased use of managed care plans as a result of the Health Maintenance Organizations Act of 1973 (P.L. 93-222) under President Nixon. According to the United States Department of Commerce Bureau of the Census (2008), enrollment in HMOs rose from 33 million Americans in 1990 to 73.9 million in 2006. Rather than move towards a preventive model and further close the coverage gap, however, the net effect of managed care has been to increase cost-sharing to the employee resulting in a reinforcement of the treatment model. Clinton’s Health Security Act was based largely in the idea of managed competition, a concept closely related to managed care. This is further evidence that the cultural path has not shifted substantially in the hundred-year history of national health care efforts.

It is of interest that in recent years, the medical profession has begun to change its stance regarding health care reform. In early 2004, the American College of Physicians (ACP), a group representing more than 115,000 internists and medical students, issued a statement to the House Ways and Means Committee Subcommittee on Health to be included in the record of their hearing on the uninsured. In the statement, the ACP (2004) acknowledges the hidden societal costs of having more than 40 million uninsured Americans and calls for “Congress [to] enact legislation to expand health insurance coverage to all Americans by the end of the decade, starting with the working poor and

near poor who do not qualify for coverage under public safety net programs and those who do not have access to affordable employer-provided and individual insurance" (p. 5).

The American Medical Association (AMA) has also revised its stance on health care reform and is using the Internet to promote its proposal (American Medical Association, 2008) called "Voice for the Uninsured." The AMA proposal rests on three points: (1) need-based subsidies for lower-income people to purchase health insurance funded partly by shifting some of the tax incentive currently enjoyed by employer-sponsored plans to vouchers or tax credits; (2) patient choice of what health plan to join; and (3) streamlining of federal and state insurance regulations to a more uniform set of standards. At least one physician group, Physicians for a National Health Program (2009), has challenged the AMA's proposal, saying that the AMA's recommendations fall short of achieving affordable, comprehensive, and universal health care.

As President Obama and the Democratic-controlled Congress look at another attempt at national health care reform, the lessons of the past should be brought to bear. Three major points from this study bear revisiting. First, knowledge of the inside legislative game and rules will be important in passing major health care legislation. Johnson understood how the Congress worked, having had 34 years of experience in the two houses, and having served as Senate Majority Leader just prior to his election to the Vice Presidency. This also meant that he had done a lot of favors and had a lot of chits he could cash in as necessary. Clinton had no experience in Washington, and few, if any, chits. His staff was young and largely inexperienced as well. Johnson's staff, by comparison, comprised seasoned political operatives and, in the case of Wilbur Cohen at least, people intimately familiar with the current Social Security system. Obama has slightly more Washington experience, with his time in the Senate, than Clinton had. How many chits he has is a matter yet to be seen, but it is unlikely he has as many as LBJ had.

Obama would be well-served to choose people to lead his health care efforts who have legislative experience as well as those with a keen understanding of the current government medical care systems. He should avoid high-profile targets in authoritative positions, unlike Clinton who named Hillary to chair the task force. Obama should also keep the administration's efforts in the hands of a fairly small and tightly-knit team as Johnson did. Clinton's task force grew to more than 600 members with every constituency represented. The result was an unwieldy mechanism where "too many cooks began to spoil the broth," as evidenced by the complexity of the final Clinton bill.

One area where Obama appears to be poised to repeat a Clinton mistake is in the area of budget reconciliation. Under Senate rules, budget reconciliation bills are not subject to filibuster. Clinton had planned to use the reconciliation process to include his health care reform package in the budget reconciliation bill. This would have eliminated the need for 60 votes to attain cloture of the Senate debate. However, the Byrd rule prohibited including anything that was not directly budget-related in a reconciliation bill. Senator Byrd was unwilling to waive the rule for health care, a decision that Hillary Clinton (2003) later acknowledged as the correct stance. Majority Leader Harry Reid (D-NV) has indicated his willingness to consider using reconciliation in place of the regular legislative process to pass top policy priorities including health care reform. Peter Orszag, Director of the Office of Management and Budget, has also refused to take reconciliation off the table on behalf of the administration. While Orszag has no real authority to make this decision, the fact that he is not taking it off the table publicly is an indicator that the administration is continuing to consider the option. The fact that Senate Majority Leader Reid is willing to go this route bodes better for an Obama success using the reconciliation rules than Byrd's leadership did for Clinton. Nevertheless, using the reconciliation

process virtually guarantees a bitter partisan battle and one that could ultimately backfire on the Democrats (Sands, 2009).

Second, Obama is more likely to succeed in bringing about major reform if he permits Congress to write the legislation. If he decides to submit legislation, he might consider making the administration proposal more modest than what he eventually hopes to achieve. Johnson's initial proposal, as an example, would have provided hospital-only coverage for the elderly and had no new provision for the medically indigent. In submitting this relatively modest proposal, as compared to the eventual outcome, Johnson left room for Mills to expand on it as he fashioned the "three-layer cake" out of the administration's proposal, the Republican proposal, and the AMA-endorsed bill. Clinton, by comparison, took almost a year to fashion his administration's proposal, striving to satisfy every constituency and provide a comprehensive bill to the Congress. In a recent television interview, Clinton indicated that he preferred to have Congress write the bill but that then-chair of the House Ways and Means Committee Dan Rostenkowski (D-IL) had insisted that the administration write the bill and allow Congress to amend it (Hirzel, 2009) Though the former President did not say so in the interview, this conversation must have occurred between election day and the inauguration, since Clinton named his wife and Ira Magaziner to head the President's Task Force on National Health Reform just five days after the inauguration (B. Clinton, 2004; H. R. Clinton, 2003; H. Johnson & Broder, 1997).. Allowing Congress to write the legislation also speaks to Johnson's ability to share credit broadly for his legislative achievements. Johnson instinctively understood that when he was sharing the spotlight, he was *in* the spotlight. Clinton seemed rather to try to play for a few big initiatives that would focus the spotlight directly on him and on Hillary.

Third, the administration needs to do what it can to control the framing of the debate (Lakoff, 2004, 2006) and the media focus. Johnson managed the message by keeping Congress busy with a flood of legislative initiatives. Clinton seems to have preferred to run one or two big initiatives at a time. Medicare and Medicaid consumed very little press attention compared to Clinton's efforts (ProQuest Historical Newspapers The Los Angeles Times [1881-1986], 2009; ProQuest Historical Newspapers The Los Angeles Times [1986-present], 2009; ProQuest Historical Newspapers The New York Times [1851-2005], 2009; ProQuest Historical Newspapers The Washington Post [1877-1992], 2009), and the Gallup Poll's Most Important Problem Question indicates that Medicare and Medicaid were far less prominent in the public's mind than were the Clinton initiatives (The Gallup Organization, 1962, 1963, 1964a, 1964b, 1964c, 1964d, 1964e, 1964f, 1964g, 1965a, 1965b, 1965c, 1992a, 1992b, 1992c, 1993a, 1993b, 1994a, 1994b, 1994c, 1994d). Johnson was aided in these respects by the media's focus on Vietnam and civil rights which deflected attention away from other domestic legislative initiatives including Medicare. Obama may be able to parlay coverage of the financial crisis and government efforts to alleviate the recession into shielding health care from the spotlight.

Hacker (1997), in his seminal work "The Road to Nowhere," made a case for why the Clinton effort failed and why any future effort at achieving universal health care is likely to fail. I am grateful to Hacker for that book on two accounts. First, it introduced me to the idea of path-dependence theory which led me to read more about it and gave me the model for this dissertation. Second, and far less importantly, it inspired the title of this chapter which is a transparent parody of Hacker's title. While I do not have the temerity to disagree completely with Hacker's argument about the future of health care, I am not yet cynical enough to agree with it either.

Now the world, including the United States, is in a great fiscal crisis precipitated by the failure of the housing market in the wake of sub-prime mortgage lending. Congress has already appropriated $700 billion to bail out the financial sector, and an $819 billion stimulus package. Some estimates go as high as $2 trillion to $3 trillion that will eventually be required to jump-start the economy. Many would, and likely will, say that this is not the time to consider expanding government health care. Still, President Obama's recently-released budget outline proposes a health-care reserve fund of $634 billion over the next ten years, and the President recently convened a White House summit on health care reform. He has taken the public position that health care reform is a fiscal necessity if the economy is to recover fully.

Uwe Reinhardt (2009), one of America's leading health economists and professor at the Woodrow Wilson School of Public Affairs at Princeton University would apparently agree. Reinhardt says that the cost to insure those presently uninsured in this country would be an estimated $122 billion per year, about twice President Obama's estimate. As Reinhardt points out, "this was once real money, but in the light of trillions of dollars to bail out the aristocracy, this is all right of the decimal point." Furthermore, Reinhardt makes the point that this would be a very quick way to infuse this money directly into the economy, since health care expenditures are fast approaching twenty percent of GDP.

President Johnson saw Medicare's passage as a sign that the country had finally begun to look at health care as a right and not a privilege (L. B. Johnson, 1971). If he was correct, it was a very slow beginning. Forty-four years later, health care is still not considered a right in the United States. Reinhardt (2009) maintains that before we get bogged down with the nuts and bolts of how such a system should work—the new HHS Secretary will have "a free army of experts" to help figure that out—we should first ask

ourselves as Americans whether we want to live in a society where a family is at risk of bankruptcy or homelessness if a member gets cancer or some other illness. What Reinhardt is asking goes to my earlier contentions on the role of culture in these decisions. How timely that I should have written that section the morning of his afternoon keynote address at the Families USA Health Action 2009 National Grassroots Meeting in Washington, DC. Reinhardt feels strongly that we must agree on this basic philosophical issue before hammering out the nuts and bolts of national health care. Whether we can achieve any philosophical consensus on universal health care access or even how various population segments should obtain health care is questionable. What seems more likely is that large corporate interests, particularly in the manufacturing sectors, will eventually demand relief from the high costs of medical care. This has the potential to lead to a Gladwell-like tipping point (Gladwell, 2002) that may actually bring a paradigmatic shift in the health care payment and delivery system—a shift that, if corporate interests demand it, could come from Republicans.

SOCIAL WORKERS AND POLICY ALLIES – ORIENTING QUESTION FOUR

So, the fourth orienting question remains: What can social workers and allied policy activists do to hasten the process by reducing political barriers, recognizing opportunities to advance reform initiatives, preparing for swift action when the path opens new policy change options, and utilizing clinical and other professional strengths to ease the transition to national health care if and when that time arises? Here I will attempt to outline what I hope will be received as concrete steps that we can take.

Step One: Train ourselves and our students to speak the languages of business and politics. For many schools of social work, policy amounts to one or two mandatory survey courses with the major focus on clinical or generalist practice skills. Social workers are in a unique position to influence policy, but many of them are poorly

trained in the skills and techniques. In addition to the human biology and statistics prerequisites of admission to many programs, I recommend that social workers have at least one survey course in economics, one in political science, and one in business management.

Our policy focus has been on social justice, and this is a noble cause. However, at the risk of being accused of cynicism, our government rarely spends money simply because it is "the right thing to do." The social contract has been badly damaged by the predator state (Galbraith, 2008). What will motivate the renewal and expansion of the welfare state in this country will be economic necessity rather than a sense of justice. If economic justice results from changes that emerge due to economic necessity, then we can also feel good about that achievement. But it is unlikely to be the cause of change.

In the case of health care reform and a move towards a) universal coverage, and b) more government involvement, a study of the outside motivators that favored Medicare should give us a clue to what will drive these changes. In the case of Medicare, the business leaders wanted to absolve themselves of responsibility for retiree health care benefits[15]. Organized labor was agreeable to this as many of their members would otherwise be without health insurance. In other words, the economics motivated the support.

Today, the automobile industry is perhaps the premiere example among many of an industry burdened by health care costs. Reinhardt (2009) goes so far as to say that "General Motors is not a car company; it is a social security system that happens to make cars." If social workers want to promote universal health care, then we must begin as a

[15] Many companies are now facing similar problems in pension obligations as well. Defined benefit plans, in particular, have the potential to wreak havoc with large employer profitability. It will be revealing to see how companies deal with these impending obligations. One possible alternative is to bankrupt the company which would push the responsibility for retiree income benefits onto the Pension Benefit Guaranty Fund of the federal government.

group to understand the economic forces that can be marshaled to motivate change; and, we must understand the economic benefits that will accrue from such a plan. Raw economic forces and interests are likely to force a cultural shift in how Americans deliver, utilize, and pay for health care. Whether that shift will meet the standards of economic justice may depend on the leadership that progressives exert on the process.

Step Two: Advocate for, seek government and/or private funding for, and actively lead in the development of a National Institute of Social Welfare Policy as part of the NIH. No one knows better than social workers that social welfare and anti-poverty policy are an integral part of a healthier society. Yet, the federal government has no central resource or funding outlet to support scientific study of these vital policies. Social workers have the advantage of a broad knowledge base rooted in multiple disciplines to bring to bear in development of such an institute. Because our knowledge base rests on the foundations of sociology, psychology, anthropology, education, and other disciplines, and given our systemic approach, we are uniquely positioned to bring these disciplines and others such as economics, public policy, political science, business, and law together to solve social welfare policy problems.

Step Three: Actively work to change the culture of health care. While this may seem like just a "tip of the cap" to the idea of culture, I believe it goes farther than this. Social workers deal every day with the public, but we do relatively little as a group to actually change the way people think. We must train ourselves and our students to frame the debate in ways that strengthen our position at the table. One minor example is the use of the words "the American taxpayer," in public discourse. The implication is that some people pay no taxes, and these people can be rightfully ignored in the policy debates. But, that simply is not true. If you live and work in the United States, you pay taxes. You may not pay income tax or pay very little income tax, but you pay regressive

sales taxes, you pay property taxes (renters pay those taxes in the form of increased rents), you pay sin taxes, and you pay corporate taxes, too, in the form of increased prices for goods. You also pay Social Security and Medicare taxes from the first dollar of earnings. “The American taxpayer” is a term used to define (and limit) who has legitimacy to engage in the debate. We are all taxpayers. Falling easily into the media and political vernacular is no excuse for social workers. We are advocates. We must advocate in ways that call for immediate action. Terms like “illegal alien” are also ways of demonizing people and justifying ignoring of their basic humanity, needs, and rights.

I am not espousing simply a bigger focus on the symbolic here or even some “politically correct” form of speech. After all, conservatives have done an excellent job of taking the idea of “political correctness” to minimize the importance of how we speak about culture. Far from that, I think progressives have focused too much on the symbols. I am talking about changing the way we think as a society; and the way you change how people think is by changing how they talk. Reinhardt (2009), again on health insurance for children, feels that neglecting the health of our children is the equivalent of wasting America’s future. You are born in this country and you get a certificate of citizenship and nobody questions that. You are entitled to a free education K-12 and nobody questions that. Reinhardt goes on to say you should be entitled to free medical care until you are 22 years old, *and nobody should question that either.* He says that Americans have come to treat their children like pets. If you want choice, then give parents an actuarially-sound, risk-adjusted voucher for each child and then require the parent to use it to insure the child or spend 30 days in jail. Social workers might find this last “punitive” idea to be a bit overboard, or even a form of social injustice. We might prefer to work to lower barriers to entry, i.e., make enrollment in Medicaid or SCHIP less onerous for parents. Either way, this would represent a real change in the culture. Social workers are uniquely

positioned to change the public discourse. We should do it now. At the very least, we should strive to expand the voice of the uninsured and underinsured. We can, and must, insist on their legitimate right to be heard. There are seven members of the House of Representatives who are social workers, and two United States Senators who are social workers in the 111th Congress. All nine are members of the Democratic Party. The represent states from Michigan to Texas and New Hampshire to California (National Association of Social Workers, 2009). Nine may not seem like a lot, but 9 members is almost 2 percent of the total number of Representatives and Senators. Social workers represent less than one-tenth of one percent of the American population. We have a good start on representation of our ideals in the American legislative branch. We should be capitalizing on that representation. Finally, we should be helping office seekers whose positions align with our values to get more votes.

Social workers must be careful in how we approach the health care culture. We cannot afford to portray ourselves as pursuing a policy course solely out of self-interest. This, in fact, is what happened in 1998 in the case of Stephens et al. v. CMG Health et al ("96 Civ. 7798 (KMW)," 1998). In this case, members of the helping professions, including clinical social workers, filed suit against a managed care organization challenging their rates of reimbursement for mental health services under restraint of trade laws. Judge Kimba Wood, a Clinton nominee for Attorney General whose nomination was derailed for having hired an undocumented immigrant, found for the defendants in the case. Judge Wood based her decision on the facts that the plaintiffs were merely protesting the buying power of managed care organizations in light of their economic self-interest in a higher rate of reimbursement. Mental health professionals are more likely to find success, if they find any at all, in the legislative branch rather than the judicial branch (Ross, 1999).

SUMMARY AND CONCLUSION

Finally, what has occurred to me repeatedly as I read and catalogued nearly 12,000 documents is the binding nature of culture on policy development. Americans' social construction of health care is far different from that of most of the developed world. We construct it not as a right, but as an economic commodity; some would go so far as to suggest that we also construct it as a privilege. Culturally, we concern ourselves more with the moral hazards of insurance than with the economically just and economically intelligent allocation of health resources. We have blunted our national conscience to the 27,000 (Lubbes, 2008) who die each year for lack of health insurance, fearful of our inability to afford their care. We have decisions to make about our society. The country's current economic situation may well force those decisions in short order. This is a good time to begin setting the tone for those decisions.

These changes will not come easily. They will require time and money and effort. Most of all, they will require leadership. Raising the bar is not an effortless task, thankless though it may be. As Americans begin to think about health care as a right, more of them will come to recognize that we are currently rationing care already. As Americans challenge the "provider and consumer choice" frame, they will have to say out loud that virtually no such choice exists in the current state of the society. (Indeed, most employers give their covered employee no choice of health plan or only a very limited choice – and all have incentives that make it virtually imperative that employees use their contract providers.)

Many Americans think of "socialized medicine" as evil. Yet, we drive on socialized roads, we are educated in socialized schools, and we are protected by socialized police and socialized fire departments. These are public goods and services,

and considering access to health care to be a public good should not be that much of a leap. Americans must be willing to stand up and say so.

The mechanisms are largely in place. Galbraith (2008) makes the point that most of the necessary infrastructure already exists to solve our economic problems thanks to the Roosevelt response to the Great Depression. Reinhardt (2009) holds that not all Americans consider government to be intrinsically evil. He points out that we have a pretty good civil service system and the *lowest* taxes of any developed nation. Government can be a place where people work together to solve common problems and provide public goods and services. That is the idea behind democracy.

That is how it is supposed to work.

Appendix A:
Glossary

Adverse Selection refers to a situation in which, usually due to information asymmetry, a purchaser's demand for insurance rises as his or her risk for loss increases, while the insurer is unable to price for this increase in demand. As an example, if insurers do not price coverage higher for smokers than for non-smokers, the insurance would be a better buy for the smoker as they are more likely to incur a claim. Smokers would thus be more likely to select the coverage than non-smokers, which would result in an adverse phenomenon (higher claims) for the insurer. Social norms and regulations may also prohibit insurers from considering certain factors (such as gender or ethnicity) in making pricing decisions. This becomes particularly problematic when underwriting, the process of selecting which risks to insure and at what price, is dismissed in favor of a guaranteed right to purchase the coverage (Cardon & Hendel, 2001; Polborn, Hoy, & Sadanand, 2004).

Association plans are group insurance plans underwritten by health insurance companies and offered to groups of people based upon their membership in some sort of organization or association. Credit unions, automobile associations, fraternal orders, and business and professional organizations are all examples of associations that typically offer such plans to their members. Many self-employed persons avail themselves of association plans if they are eligible for them in lieu of typically more expensive individual plans.

Chargemaster Lists are the master lists of hospital charges for each procedure or supply offered in a given hospital. The chargemaster list is generally closely-held and not available to the general public (G. F. Anderson, 2007).

Co-insurance is generally expressed as a percentage of approved charges after the deductible has been paid by the insured. This is usually in the range of 20 percent of charges, though it may be higher if the insured chooses a provider who does not have a negotiated pricing agreement with the insurer. Co-insurance, like deductibles and co-payments, acts to reduce *ex post* moral hazard (see below) by discouraging patients from utilizing more expensive procedures when less expensive procedures will suffice. Co-insurance is usually capped by an out-of-pocket maximum amount above which the insurance company pays 100 percent of approved charges.

Comprehensive Coverage is sometimes referred to in the health insurance market as "major medical." Comprehensive coverage pays based upon some negotiated price or percentage of actual charges. Indemnity plans (see below) pay a set fee for each service, e.g., $25 per day of hospitalization.

Co-payment is a flat fee per service rendered which must be paid by the consumer at the time of service. Typically in the $10 to $50 range for a doctor's visit, depending on whether a generalist or a specialist, the premise behind co-payments is to reduce the incentive of the insured to overutilize medical services (see "moral hazard" below). Co-payments may also be applied to hospital stays, emergency room visits (usually for non-emergencies), and prescription drugs as well as other charges.

Deductibles are an amount which must be paid out of the insured's pocket before insurance pays anything for services. Unlike co-payments, deductibles are cumulative and generally start over at the beginning of each insurance plan year. Co-payments do not count toward deductible requirements, nor do co-payments usually cease to apply once deductibles are met. Higher deductibles generally result in lower premiums, as the insurance company has less exposure to *ex post* moral hazard (see below).

Experience-rated group health insurance is the type of insurance provided by most employers, especially those not large enough to self-insure (see "self-insured plans" below). These policies are purchased by the employer from a group health insurance company. The premiums are based upon the previous claims experience of the employer. If an employer has a large number of expensive claims, that employer can expect its premiums to increase the following renewal period (usually a year) much more rapidly than employers who have healthier (or at least smaller-claims producing) employees and dependents.

Gross Domestic Product (GDP) is the total value of goods and services produced in a given country's economy in a year. In the United States, GDP is expressed in U.S. Dollars (Sullivan & Sheffrin, 2003).

Indemnity Coverage or indemnity plans refers to insurance plans that pay a set fee per procedure or day of hospitalization. Indemnity coverage is less expensive than comprehensive coverage (see above) in general, but it provides significantly fewer benefits as well.

Legislative Tempo, as I use it in this dissertation, refers to the amount and type of legislation being submitted to Congress by the executive branch.

Managed Care refers to programs or organizations whose goal is to reduce the cost of providing health care while improving the quality of the care delivered. The term encompasses a variety of techniques and methods including economic incentives to physicians and patients to select less costly care, increased cost-sharing with beneficiaries, and controls on hospital admissions and lengths of hospital stays (MeSH, n.d.)

Moral Hazard refers to the tendency of a party who is insulated from a risk to behave differently than if the party were fully exposed to the risk. In health insurance

markets, this means that insured persons may either engage in more risky behavior (e.g., start smoking once covered), which is called *ex ante* moral hazard, or may ask the insurer to pay for more covered services once insured (e.g., more doctor visits), which is called *ex post* moral hazard (Arrow, 1971). The usually methods of countering the *ex post* moral hazard are deductibles, co-payments, and coinsurance. Without these direct costs to the insured person, there would be no economic incentive to avoid going to the doctor whenever possible. The net result, however, is that poorer people, those who may have trouble paying the deductibles or co-payments, may postpone treatment until such time as they can no longer do so resulting in an increased cost overall to the insurer.

Risk pool is the group of risks being covered by an insurer (government or private). Generally, it refers to the people who will be covered by an insurer and the insured losses which they may incur over a given period of time. Pooling risk is a basic principle of insurance. Everyone in the pool pays a premium to be insured against a risk. Usually a limited number of people will actually incur an insured loss. The premiums collected are then used to pay for the cost of the insured loss. In the case of private for-profit companies, an additional amount must be included in the premium for profit for the company as well as overhead expenses.

Self-insured plans are private employer-provided plans where the employing corporation provides the funds for claims itself rather than relying on an insurance company. In many cases, self-insured plans hire a third-party administrator (often an insurance company) to actually process and pay the claims while they collect any premiums and supply the funds for the claims out of the corporation's profits. Such plans are almost exclusively the domain of very large corporations and, in some cases, government or quasi-governmental agencies such as universities. In some cases, self-insured companies may elect to purchase so-called "stop loss" insurance. This is

relatively low-cost insurance that picks up when a given employee's claims reach a pre-determined limit, e.g., $500,000, with any risk above that amount borne by an insurance carrier instead of by the employer itself.

Socialized Medicine refers to systems in which the government provides medical care directly to the public through government-employed providers. Often raised as a rallying cry against universal health care in the United States, many Western countries do not, in fact, have true socialized medicine. Rather, they have single-payer insurance where the government covers the costs of privately provided care.

Worker's Compensation Insurance covers medical expenses and lost wages due to job-related injury or illness. Most states require employers who employ more than a minimum number of employees to carry worker's compensation insurance.

Appendix B:
Demographics of the Uninsured in America

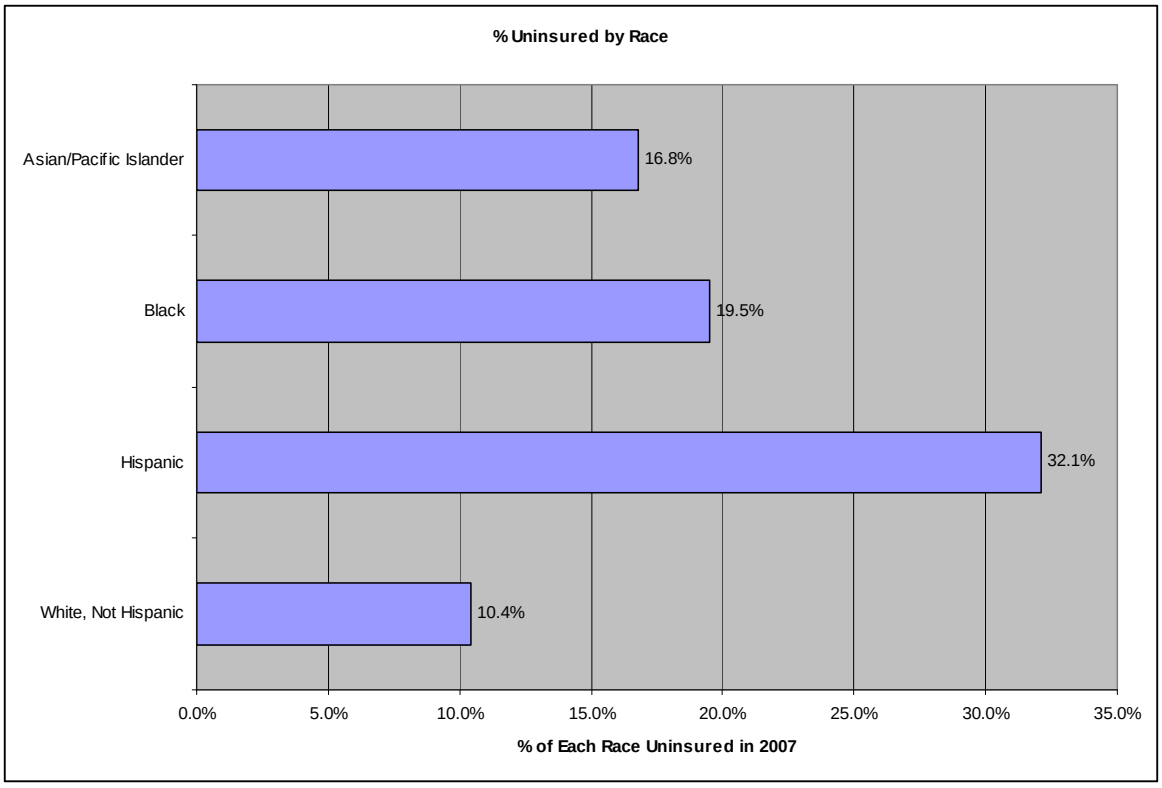


Figure 12: Percent of Each Race That Was Uninsured During 2007 [DeNavas-Walt, et al. (2008)]

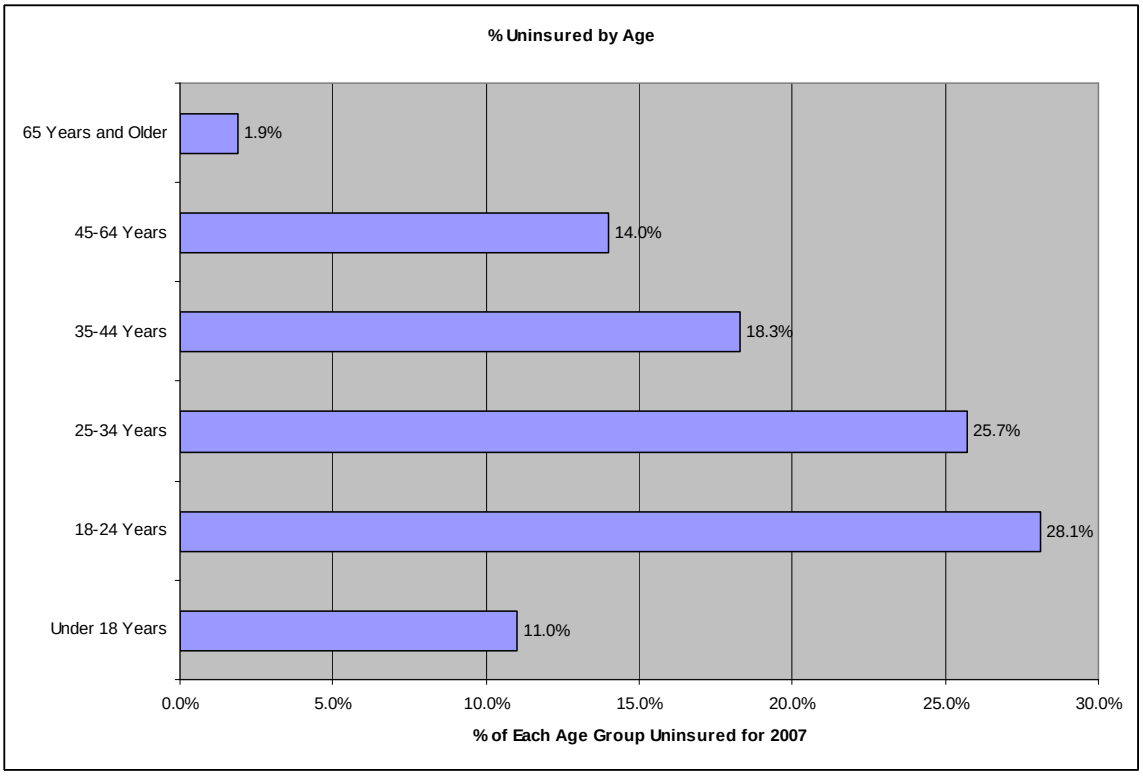


Figure 13: Percent of Each Age Grouping That Was Uninsured During 2007 [DeNavas-Walt, et al. (2008)]

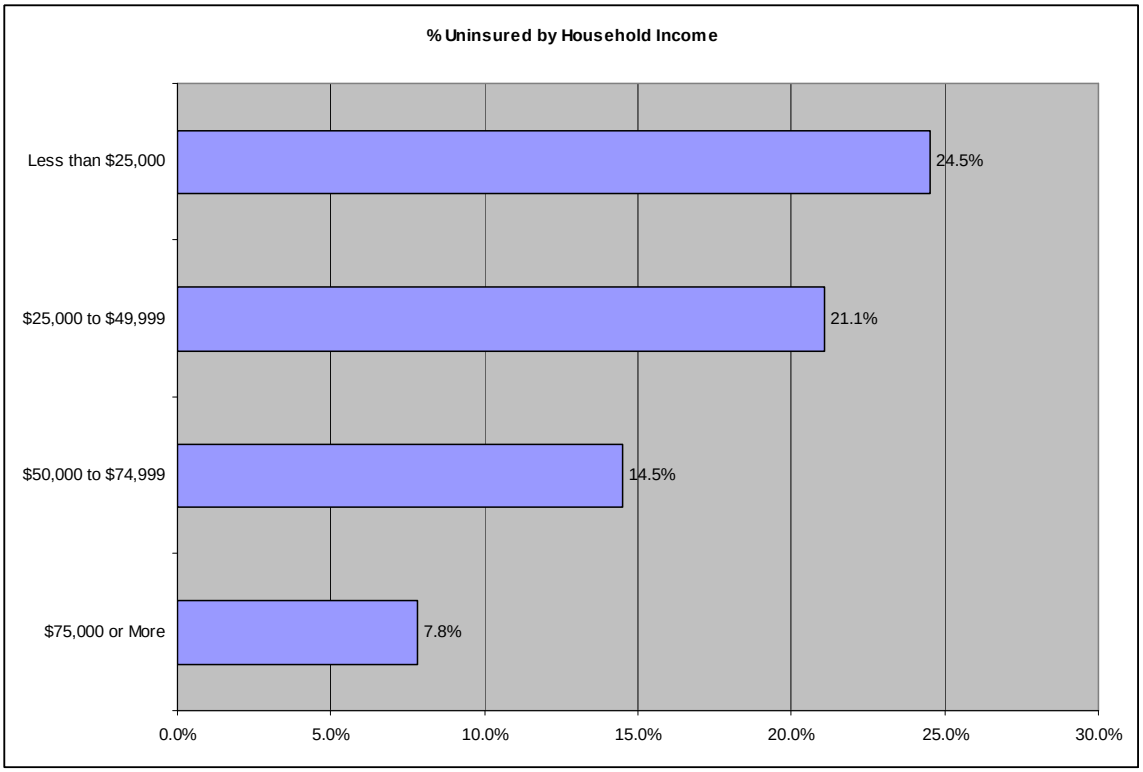


Figure 14: Percent of Each Household Income Category That Was Uninsured During 2007 [DeNavas-Walt, et al. (2008)]

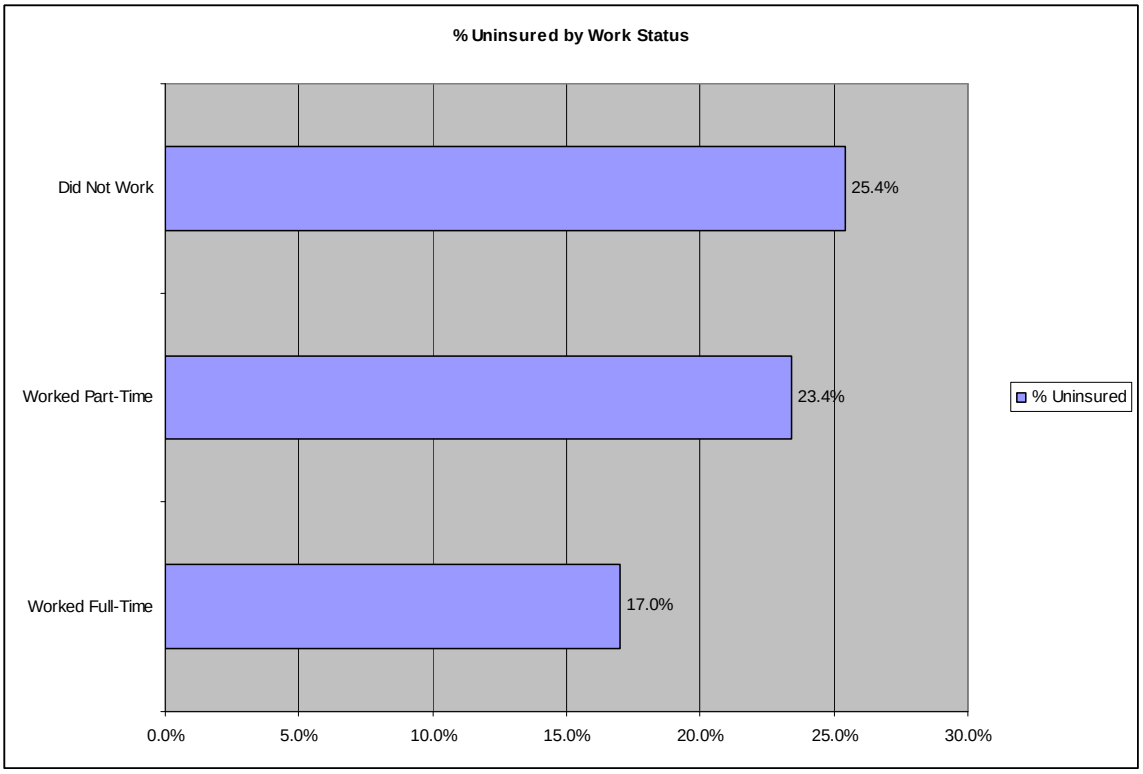


Figure 15: Percent of Each Working Status That Was Uninsured During 2007 [DeNavas-Walt, et al. (2008)]

Bibliography

5 USC IIIB Chaper 31 §3110. Employment of relatives; restrictions § 5 USC IIIB Chaper 31 §3110 (1967).

Acs, G., & Sabelhaus, J. (1995). Trends in out-of-pocket spending on health care, 1980-92. *Monthly Labor Review Online, 118*(12), 35-45. Retrieved from http://www.bls.gov/opub/mlr/1995/12/art4full.pdf.

American College of Physicians (2004). Statement of the American College of Physicians to the Ways and Means Committee, Subcommittee on Health for the record of the hearing on the uninsured, March 9, 2004. Retrieved April 11, 2009, from American College of Physicians: http://www.acponline.org/advocacy/where_we_stand/access/way_means04.pdf.

American Medical Association (2008). AMA (Uninsured) Voice for the Uninsured Web Site. Retrieved April 11, 2009, from American Medical Association: http://www.voicefortheuninsured.org/amaproposal.html.

Anderson, C. P. (1965). Letter from Clinton P. Anderson to Lyndon Baines Johnson, July 1, 1965. LBJ Library.

Anderson, G. F. (2007). From 'soak the rich' to 'soak the poor':Recent trends in hospital pricing. *Health Affairs, 26*(3), 780-789.

Arrow, K. (1971). *Essays in the theory of risk-bearing*. Chicago: Markham.

Arthur, W. B. (1994). *Increasing returns and path dependence in the economy*. Ann Arbor, MI: University of Michigan Press.

Auger, R. C., & Goldberg, V. P. (1974). PREPAID HEALTH PLANS AND MORAL HAZARD. *Public Policy, 22*(3), 353-397.

Bennefield, R. L. (1995). *Current population reports: Household economic studies*. Washington, DC: U.S. Census Bureau.

Bhide, A. (2009, April 9). You can't rush a recovery: While small business struggles, Goldman Sachs was protected from its AIG mistakes. *The Wall Street Journal*, p. A15. Retrieved April 10, 2009, from http://online.wsj.com/article/SB123923669256903421.html.

Blinder, M., & Greenberg, S. (1993). Memo from Madeline Blinder and Sue Greenberg to Chris Jennings, Howard Paster, Goody Marshall, and Christine Varney, November 5, 1993. Clinton Presidential Library.

Boston, D. W. (1964). Letter from Don W. Boston, M.D. to Bill Moyers, September 12, 1964. LBJ Library.

Brosco, J. P. (1994). *Sin or folly: Child and community health in Philadelphia, 1900-1930*. Unpublished Ph.D., University of Pennsylvania, United States -- Pennsylvania.

Bruning, F. (1996). Will the real Hillary Clinton please stand up? *Maclean's*, p. 15. from http://ezproxy.lib.utexas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=9603067752&site=ehost-live.

Buckley, J. E., & Van Giezen, R. W. (2004). Federal statistics on healthcare benefits and cost trends: An overview. *Monthly Labor Review Online, 127*(11), 43-56. Retrieved from http://www.bls.gov/opub/mlr/1995/12/art4full.pdf

Buckley Jr, W. F. (1993). Oh Dear, Hillary. *National Review*, *45*(5), 70-70.

Bullock, A., & Stallybrass, O., eds. (1977). *The Harper Dictionary of Modern Thought*. New York: Harper.

Burden, B. C., & Mughan, A. (1999). Public opinion and Hillary Rodham Clinton. *Public Opinion Quarterly*, *63*(2), 237-250.

Busby, H. (1964). Memo from Horace Busby to Lyndon Baines Johnson, August 4, 1964. LBJ Library.

Busby, H. (1965). Memo from Horace Busby to Jack Valenti, Douglass Cater, Bill Moyers, and Marvin Watson, July 22, 1965. LBJ Library.

Byrd, H. F. (1965). Letter from Harry F. Byrd to Anthony Celebrezze, April 13, 1965. LBJ Library.

Campbell, P. C. (1949). *The consumer interest: A study in consumer economics*. New York: Ayer Company Publishers.

Campion, F. D. (1984). *The AMA and U.S. health policy since 1940*. Chicago: Chicago Review Press.

Cardon, J. H., & Hendel, I. (2001). Asymmetric information in health insurance: Evidence from the national medical expenditure survey. *The RAND Journal of Economics, 32*(3), 408-427.

Carlson, M., & August, M. (1992). A different kind of first lady. (cover story). *Time, 140*(20), 40.

Caro, R. A. (1982). *The years of Lyndon Johnson: The path to power*. New York: Alfred A. Knopf.

Caro, R. A. (1990). *The years of Lyndon Johnson: Means of ascent*. New York: Alfred A. Knopf.

Caro, R. A. (2002). *The years of Lyndon Johnson: Master of the Senate*. New York: Alfred A. Knopf.

Cater, D. (1965). Memo from Douglass Cater to Lyndon Baines Johnson, February 18, 1965. LBJ Library.

Celebrezze, A. (1964). Memo from Anthony Celebrezze to Lyndon Baines Johnson, November 25, 1964. LBJ Library.

Centers for Medicare & Medicaid Services (2009). Table 1, National health expenditures aggregate, per capita amounts, percent distribution, and average annual percent growth, by source of funds: Selected calendar years 1960-2007 Retrieved February 18, 2009, from http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

Chafe, W. H. (1999). *The Unfinished Journey: America Since World War II* (4th ed.). New York: Oxford University Press.

Chambers, L. (1994). Letter from Letitia Chambers to William Jefferson Clinton, August 25, 1994. Clinton Presidential Library.

Clift, E., & Miller, M. (1992). Hillary: Behind the scenes. *Newsweek, 120*(26), 23.

Clinton, B. (2004). *My Life*. New York: Random House.

Clinton, H. R. (2003). *Living History*. New York: Scribner.

Clinton, W. J. (1993a). Handwritten note from William Jefferson Clinton to Ira Magaziner. Clinton Presidential Library.

Clinton, W. J. (1993b). Statement of President Clinton: The White House January 25, 1993 Retrieved November 11, 2006, from http://www.ibiblio.org/darlene/task.

Clymer, A. (1994, August 25). The health care debate: The senate; Clinton says coalition plan lacks scope. *The New York Times*. Retrieved January 29, 2009, from http://query.nytimes.com/gst/fullpage.html?sec=health&res=9E03E2DC1339F936A1575BC0A962958260.

CMS Office of Public Affairs (2009). *CMS reports lowest rate of overall growth in national health spending since 1998*. Retrieved April 17, 2009. from http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3390&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date.

Cohen, W. J. (1964a). Memo from Wilbur J. Cohen to HEW Secretary Anthony Celebrezze, July 13, 1964. LBJ Library.

Cohen, W. J. (1964b). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, December 23, 1964. LBJ Library.

Cohen, W. J. (1965a). Memo from Wilbur J. Cohen to HEW Secretary Anthony Celebrezze, February 3, 1965. LBJ Library.

Cohen, W. J. (1965b). Memo from Wilbur J. Cohen to HEW Secretary Anthony Celebrezze, January 28, 1965. LBJ Library.

Cohen, W. J. (1965c). Memo from Wilbur J. Cohen to Horace Busby, July 26, 1965. LBJ Library.

Cohen, W. J. (1965d). Memo from Wilbur J. Cohen to Jack Valenti, March 4, 1965. LBJ Library.

Cohen, W. J. (1965e). Memo from Wilbur J. Cohen to Jack Valenti, March 8, 1965, attaching draft language of letter to be sent to Ribicoff by LBJ. LBJ Library.

Cohen, W. J. (1965f). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, March 11, 1965. LBJ Library.

Cohen, W. J. (1965g). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, March 12, 1965. LBJ Library.

Cohen, W. J. (1965h). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, March 15, 1965. LBJ Library.

Cohen, W. J. (1965i). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, March 16, 1965. LBJ Library.

Cohen, W. J. (1965j). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, March 17, 1965. LBJ Library.

Cohen, W. J. (1965k). Memo from Wilbur J. Cohen to Lawrence F. O'Brien, May 6, 1965. LBJ Library.

Cohen, W. J. (1965l). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, February 25, 1965. LBJ Library.

Cohen, W. J. (1965m). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, January 29, 1965. LBJ Library.

Cohen, W. J. (1965n). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, June 17, 1965. LBJ Library.

Cohen, W. J. (1965o). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, June 24, 1965. LBJ Library.

Cohen, W. J. (1965p). Memo from Wilbur J. Cohen to Lyndon Baines Johnson, March 2, 1965. LBJ Library.

Cohen, W. J. (n.d.). The Kennedy-Mills Compromise (1963). Unpublished Handwritten Notes. LBJ Library.

Cohen, W. J., & McComb, D. (Producer). (1968) Transcript, Wilbur J. Cohen Oral History Interview, 12/8/1968, by David McComb, tape 1.

Comparison of Chafee/Dole legislation to Clinton proposal (n.d.). Clinton Presidential Library.

Cooper, M., & Gest, T. (1992). The Hillary factor. (cover story). *U.S. News & World Report, 112*(16), 30.

Cowan, C., Catlin, A., Smith, C., & Sensening, A. (2004). National health expenditures, 2002. *Health Care Financing Review, 25*(4), 143-166.

Creswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications.

Cruikshank, N. H. (1964). Note from Nelson Cruikshank to Jack Valenti attaching telegram from Cruikshank and Elizabeth "Wicky" Wickenden of 9/3/64, September 4, 1964. LBJ Library.

The dangers of price controls (1993). Clinton Presidential Library.

Daschle, T. (2008). *Critical: What we can do about the health-care crisis*. New York: Thomas Dunne Books.

David, S. I. (1985). *With dignity: The search for Medicare and Medicaid*. Westport, CT: Greenwood Press.

Deacon, J., & Mackenzie, H. (1993). Mr. & Mrs. President. (cover story). *Maclean's, 106*(5), 38.

Democratic Leadership Council (2008). DLC Bruce Reed Bio Retrieved January 21, 2009, from http://www.ppionline.org/ndol/ndol_ci.cfm?kaid=86&subid=191&contentid=3420.

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2007). *Income, Poverty and Health Insurance Coverage in the United States: 2006*. from http://www.census.gov/prod/2007pubs/p60-233.pdf.

DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2008). *Income, Poverty and Health Insurance Coverage in the United States: 2007*. from http://www.census.gov/prod/2007pubs/p60-233.pdf.

Diesing, P. (1991). *How Does Social Science Work? Reflections on Practice*. Pittsburgh, PA: University of Pittsburgh Press.

Ditzell, J. F. (1965). Letter from J.F. Ditzell to Harry Byrd, April 12, 1965. LBJ Library.

Donaldson, C., & Gerard, K. (1989). Countering moral hazard in public and private health care systems: a review of recent evidence. *Journal Of Social Policy, 18*(2), 235-251.

Dye, T. R. (2007). *Understanding Public Policy* (12th ed.). Upper Saddle River, N.J.: Pearson Prentice Hall.

Esselstyn, C. B. (1963). Letter from Caldwell B. Esselstyn, M.D. to Lyndon Baines Johnson, December 4, 1963. LBJ Library.

Families USA (2007a). *Medicare Part D drug prices are climbing quickly*. Washington, DC: Families USA.

Families USA (2007b). *No bargain: Medicare drug plans deliver higher prices*. Washington, DC: Families USA.

Furman, B., Special to THE NEW YORK TIMES (1947, July 12). LASKER SUPPORTS HEALTH INSURANCE: Foe of Cancer Talks 4 Hours to Senate Group in Favor of the Murray Bill. *New York Times*, p. 16. Retrieved January 5, 2009.

Furst, K. A. (1993). Fax from Kurt A. Furst to Chris Jennings, April 28, 1993. Clinton Presidential Library.

Gadamer, H.-G. (1960). *Truth and method* (G. Barden, Trans.). New York: Continuum.

Galbraith, J. K. (2008). *The predator state: How conservatives abandoned the free market and why liberals should too*. New York: The Free Press.

Gladwell, M. (2002). *The tipping point: How little things can make a big difference*. New York: Little, Brown and Company.

Goldfield, N. (1992). The paradoxes of national health reform during the Wilson era. (Woodrow Wilson) (National Health Policy). *Physician Executive, v18*(n5), p7(8).

Goldschmidt, A. E., & Wickenden, E. (1969). Transcript of Arthur E. Goldschmidt Elizabeth Wickenden (Mrs. Goldschmidt) Oral History Interview, 6/3/1969, by Paige Mulhollan, LBJ Library.

Goldschmidt, E. W. (1974). Transcript of Elizabeth Wickenden Goldschmidt Oral History Interview, 11/6/1974, by Michael L. Gillette, LBJ Library.

Goldwater, B. (1965, April 23). Medicare's final cost isn't fully realized. *The Los Angeles Times*, p. A5. Retrieved February 28, 2009.

Goodwin, D. K. (1991). *Lyndon Johnson and the American Dream* (2nd ed.). New York: St. Martin's Griffin.

Gordon, K. (1965). Memo from Kermit Gordon to Lyndon Baines Johnson, March 3, 1965. LBJ Library.

Green, S., & Hornblower, M., Washington Post Staff Writers (1974, October 11). Mills Admits Being Present During Tidal Basin Scuffle: Mills States Role in Incident. *The Washington Post (1974-Current File)*, p. A1. Retrieved January 19, 2009.

Griffin, P. (1994a). Memo from Pat Griffin to Leon Panetta, July 8, 1994. Clinton Presidential Library.

Griffin, P. (1994b). Memo from Pat Griffin to William Jefferson Clinton, February 8, 1994. Clinton Presidential Library.

Griffin, P. (1994c). Memo from Pat Griffin to William Jefferson Clinton, February 22, 1994. Clinton Presidential Library.

Griffin, P. (1994d). Memo from Pat Griffin to William Jefferson Clinton, January 31, 1994. Clinton Presidential Library.

Grubin, D. (Writer) (1991). LBJ [Television Series]. In D. Grubin (Producer), *The American Experience*. USA: Public Broadcasting System.

Hacker, J. S. (1997). *The road to nowhere: The genesis of President Clinton's plan for health security*. Princeton, NJ: Princeton University Press.

Hacker, J. S. (1998). The historical logic of national health insurance: Structure and sequence in the development of British, Canadian, and U.S. medical policy. *Studies in American Political Development, 12*, 57-130.

Hacker, J. S., & Pierson, P. (2005). *Off Center: The Republican Revolution & the Erosion of American Democracy*. New Haven, CT: Yale University Press.

Hancock, M., Armey, D., Gingrich, N., Dreier, D., Kasich, J. R., Walker, B., et al. (1993). Letter to William Jefferson Clinton, October 18, 1993. Clinton Presidential Library.

Hawthorne, F. (2007). *To keep health plans, many firms shift costs*: BlueCross BlueShield Association.

Health Care University Concept/Implementation Proposal (1993). Clinton Presidential Library.

Herman, A. (1994). Memo from Alexis Herman to William Jefferson Clinton, August 25, 1994. Clinton Presidential Library.

Herzlinger, R. (2007). *Who killed health care? America's $2 trillion medical problem -- and the consumer-driven cure*. New York: McGraw-Hill.

Higley, J., & Burton, M. (2006). *Elite Foundations of Liberal Democracy*. Lanham, MD: Rowman and Littlefield Publishers, Inc.

Himmelstein, D. U., Warren, E., Thorne, D., & Woolhandler, S. (2005). Illness And Injury As Contributors To Bankruptcy. *Health Affairs*, *24*, 63-73.

Hinz, R. P. (1993). Memo from Richard P. Hinz to Hillary Rodham Clinton, July 11, 1993. Clinton Presidential Library.

Hirzel, C. (Writer) (2009). Interview with Bill Clinton by Sanjay Gupta. In H. Waters (Producer), *Larry King Live*: CNN.

Hitt, G., & Weisman, J. (2009, February 14). Recovery package gets congressional approval: House Democrats pass $787 billion measure without GOP support as Senate sends bill to White House. *The Wall Street Journal*, p. A2. Retrieved April 10, 2009, from http://online.wsj.com/article/SB123453885966183349.html.

Hofferbert, R. I. (1986). PERSPECTIVES ON PUBLIC POLICY. *Policy Studies Review*, *5*(3), 511-519.

Hoffman, B. R. (1996). *Health insurance and the making of the American welfare state, 1915-1920*. Unpublished Ph.D., Rutgers The State University of New Jersey - New Brunswick, United States -- New Jersey.

Hunter, M., Special to The New York Times, (1964, November 12). MILLS GIVES WAY ON AGED CARE BILL: Says He Will Let Committee Act on Health

Program if President Asks Him. *New York Times*, p. 1. Retrieved January 15, 2009.

Ickes, H. (1994). Memo from Harold Ickes to Ira Magaziner, September 8, 1994. Clinton Presidential Library.

INQUIRY ON AGED OPENS: 2 Senators Start 7-City Tour With Hearings at Boston. (1959, October 14). *New York Times*, p. 19. Retrieved January 5, 2009.

Javits, J. K. (1964a). Congressional Record: Proceedings and debates of the 88th Congress, Second Session, Vol. 110, No. 8. Unpublished "Reprint in Folder LE/IS 1 11/22/63-2/20/64, White House Central Files Box 75, LE/IS". LBJ Library.

Javits, J. K. (1964b). Letter from Jacob K. Javits to Lyndon Baines Johnson, January 27, 1964. LBJ Library.

Jennings, C. (1993). Memo from Chris Jennings to Hillary Rodham Clinton, November 19, 1993. Clinton Presidential Library.

Jennings, C. (1994). Memo from Chris Jennings to Ira N. Forman, June 3, 1994. Clinton Presidential Library.

Jennings, C., & Edelstein, S. (1993a). Memo from Chris Jennings and Steve Edelstein to Bob Boorstin, Jeff Eller, Christine Heenan, et al, July 26, 1993. Clinton Presidential Library.

Jennings, C., & Edelstein, S. (1993b). Memo from Chris Jennings and Steve Edelstein to Hillary Rodham Clinton, May 6, 1993. Clinton Presidential Library.

Jennings, C., & Edelstein, S. (1993c). Memo from Chris Jennings and Steve Edelstein to Jeff Eller, July 20, 1993. Clinton Presidential Library.

Johnson's Special Message to Congress Outlining Broad National Health Program (1965, January 8). *New York Times*, p. 16. Retrieved January 15, 2009.

Johnson, H., & Broder, D. S. (1997). *The System: The American way of politics at the breaking point*. Boston: Little, Brown and Company.

Johnson, L. B. (1950). Letter from Lyndon Baines Johnson to Mrs. Thos. P. Caughlin. LBJ Library.

Johnson, L. B. (1965a). Carbon copy of letter from Lyndon Baines Johnson to Abraham Ribicoff, March 8, 1965, with handwritten notation 'not sent'. LBJ Library.

Johnson, L. B. (1965b). Letter from Lyndon Baines Johnson to Abraham Ribicoff, March 8, 1965, signature space cut away. LBJ Library.

Johnson, L. B. (1965c). Letter from Lyndon Baines Johnson to John W. McCormack, April 9, 1965. LBJ Library.

Johnson, L. B. (1965d, May 17, 2006). President Lyndon B. Johnson's Remarks With President Truman at the Signing in Independence of the Medicare Bill Retrieved November 11, 2006, from http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp.

Johnson, L. B. (1971). *The vantage point: Perspectives of the presidency 1963-1969*. New York: Holt, Rinehart and Winston.

Kaiser Commission on Medicaid and the Uninsured (2006). *The Uninsured: A Primer* (pdf file). Washington, D.D.: The Henry J. Kaiser Family Foundation.

Kaiser Commission on Medicaid and the Uninsured (2007). *Health Care Costs: A Primer* (pdf file). Washington, D.D.: The Henry J. Kaiser Family Foundation.

Kaiser Family Foundation (2009a). Concentration of health care spending in the population, 2006 Retrieved February 17, 2009, from http://facts.kff.org/chart.aspx?ch=822.

Kaiser Family Foundation (2009b). Distribution of personal health care expenditures by source of payment, 1997 and 2007 Retrieved February 17, 2009, from http://facts.kff.org/chart.aspx?ch=621.

Kasich, J. R., Ranking Republican, & Republican Members House Committee on the Budget (1993). White Paper on Health Care Reform, May 20, 1993. Clinton Presidential Library.

Kearns, D. (1976). *Lyndon Johnson and the American Dream*. Norwalk, CT: The Easton Press.

Kennedy, J. F. (1963-1966). *Public Papers of the Presidents of the United States, 1960-1963*.

Kessel, R. A. (1958). Price-discrimination in medicine. *Journal of Law & Economics, 1 (OCT)*, 20-53.

Key, V. O., Jr., (1966). *The responsible electorate*. New York: Vintage Books.

Kim, J.-W. (1990). *A study of the early implementation of the Maternal and Infant Health Improvement Act.* Unpublished Ph.D., The University of Texas at Austin, United States -- Texas.

Kinsley, M. (1994, January 30, 1994). Inevitable health-care cutbacks. *Pittsburgh Post-Gazette*, p. D3. Retrieved January 20, 2009, from http://www.lexisnexis.com.ezproxy.lib.utexas.edu/us/lnacademic/results/docview/docview.do?docLinkInd=true&risb=21_T5662528995&format=GNBFI&sort=BOOLEAN&startDocNo=1&resultsUrlKey=29_T5662528998&cisb=22_T5662528997&treeMax=true&treeWidth=0&csi=144577&docNo=1.

Koop, C. E. (1993). C. Everett Koop, M.D., Remarks, Health Care University, September 20, 1993. Clinton Presidential Library.

Korczyk, S. M. (1993). Memo from Sophie Korczyk to Rob Lively, April 30, 1993. Clinton Presidential Library.

Kotlikoff, L. J. (2007). *The Healthcare Fix: Universal Insurance for All Americans*. Cambridge, MA: The MIT Press.

Kreader, J. L. (1988). *America's prophet for social security: A biography of Isaac Max Rubinow*. Unpublished Ph.D., The University of Chicago, United States -- Illinois.

Lakoff, G. (2004). *Don't think of an elephant: Know your values and frame the debate -- the essential guide for progressives*. White River Junction, VT: Chelsea Green.

Lakoff, G. (2005). George Lakoff. *Tikkun, 20*(6), 26-29.

Lakoff, G. (2006). *Thinking Points: Communicating Our American Values and Vision*. New York: Farrar, Straus, and Giroux.

Lay, K. L. (1993). Letter from Kenneth L. Lay to William Jefferson Clinton, September 22, 1993. Clinton Presidential Library.

Lejano, R. P. (2006). *Frameworks for policy analysis: Merging text and context*. New York: Routledge / Taylor & Francis Group.

Levey, N. N. (2009). Taxes on healthcare benefits?; The idea, once nearly taboo, is on the table as lawmakers of both parties consider a system overhaul. *Los Angeles Times*, p. A.17. from http://proquest.umi.com/pqdweb?did=1668605411&Fmt=7&clientId=48776&RQT=309&VName=PQD.

Levi, M. (1997). A model, a method, and a map: Rational choice in comparative and historical analysis. In M. I. Lichbach & A. S. Zuckerman (Eds.), *Comparative Politics: Rationality, Culture, and Structure* (pp. 19-41). Cambridge: Cambridge University Press.

Lewin-VHI (1993). Executive Summary: The Financial Impact of the Health Security Act. Clinton Presidential Library.

Lexington (2009, May 2). Party-hopping: Arlen Specter has shifted the balance of power in Washington yet farther to the left. *The Economist*.

Lindblom, C. E., & Woodhouse, E. J. (1993). *The Policy-Making Process* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Lubbes, S. (2008, January 14). Thousands of U.S. deaths attributed to lack of health insurance. *Washington Health Policy Week in Review*.

Lux, M. (1993). Memo from Mike Lux to Hillary Rodham Clinton, May 5, 1993. Clinton Presidential Library.

Lux, M., & Yager, M. (1993). Memo from Mike Lux and Marilyn Yager to Steve Ricchetti, Chris Jennings, and Melanie Verveer, September 28, 1993. Clinton Presidential Library.

Lyndon Baines Johnson Library and Museum (2006, July 1, 2006). President Lyndon B. Johnson's Biography Retrieved September 13, 2007, 2007, from http://www.lbjlib.utexas.edu/johnson/archives.hom/biographys.hom/lbj_bio.asp.

Ma, C.-T. A., & Riordan, M. H. (2002). Health Insurance, Moral Hazard, and Managed Care. *Journal of Economics & Management Strategy, 11*(1), 81-107.

Magaziner, I., & Jennings, C. (1994). Privileged and Confidential Memorandum from Ira Magaziner and Chris Jennings to President Clinton (cc: Hillary Rodham Clinton) , January 6, 1994. Clinton Presidential Library.

Mahoney, J., & Rueschemeyer, D. (Eds.). (2003). *Comparative historical analysis in the social sciences*. New York: Cambridge University Press.

Mainstream Coalition Proposed Agreement, June 27, 1994, 3 a.m. (1994). Clinton Presidential Library.

Mainstream Coalition Proposed Agreement, June 27, 1994, 6 p.m. (1994). Clinton Presidential Library.

Mainstream Coalition Proposed Agreement, June 27, 1994, 12:15 p.m. (1994). Clinton Presidential Library.

Mainstream Coalition Staff (1994). Memo from Mainstream Coalition Staff to Mainstream Senators, September 13, 1994. Clinton Presidential Library.

Manatos, M. (1964a). Memo from Mike Manatos to Larry O'Brien summarizing meeting between the two of them and Senators Mike Mansfield, Hubert Humphrey, Clinton Anderson, and Abraham Ribicoff, August 14, 1964. LBJ Library.

Manatos, M. (1964b). Memo from Mike Manatos to Larry O'Brien, December 8, 1964. LBJ Library.

Manatos, M. (1964c). Memo from Mike Manatos to Mike Feldman, October 1, 1964. LBJ Library.

Marmor, T. R. (2000). *The Politics of Medicare* (2nd ed.). New York: Aldine de Gruyter.

Mazmanian, D. A., & Sabatier, P. A. (1980). A Multivariate Model of Public Policy-Making. *American Journal of Political Science, 24*(3), 439-468.

McCaughey, E. (1994a). No exit: What the Clinton plan wil do for you. *New Republic, 210*(6), 21-25.

McCaughey, E. (1994b). No exit: What the Clinton plan will do for you. *New Republic, 210*(6), 21-25.

McCombs, M. (2004). *Setting the agenda: The mass media and public opinion*. Malden, MA: Blackwell Publishing.

McCombs, M. (2005). A Look at Agenda-setting: past, present and future. *Journalism Studies, 6*(4), 543-557.

Meckler, L. (2009, February 18). Obama signs stimulus into law. *The Wall Street Journal*. Retrieved April 10, 2009, from http://online.wsj.com/article/SB123487951033799545.html.

MEDICARE MEASURE OFFERED IN SENATE (1965, January 7). *New York Times,* p. 31. Retrieved January 15, 2009.

Merlis, M. (2003). *The Federal Employees Health Benefits Program: Program design, recent performance, and implications for medicare reform* (PowerPoint Presentation): The Kaiser Family Foundation.

MeSH (n.d.). Managed care programs: MeSH result. Retrieved April 19, 2009, from National Library of Medicine: http://www.ncbi.nlm.nih.gov/sites/entrez.

Millner, L. (1991). *Maternal and infant health: Painful policy choices in Congress, 1935-1987*. Unpublished Ph.D., Bryn Mawr College, Graduate School of Social Work and Social Research, United States -- Pennsylvania.

Mills, W. D. (1971). Transcript of Wilbur Mills Oral History Interview I, 11/2/1971, by Joe B. Frantz, Internet Copy, LBJ Library.

Mills, W. D. (1987a). Transcript of Wilbur Mills Oral History Interview II, 3/25/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

Mills, W. D. (1987b). Transcript of Wilbur Mills Oral History Interview III, 5/15/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

Molitor, V. C. (1964). Letter from Vinne Clark (Mrs. Nicholas) Molitor to Lyndon Baines Johnson, January 8, 1964. LBJ Library.

Morris, D., & McGann, E. (2004). *Because He Could*. New York: Regan Books / HarperCollins Publishers.

Morris, J. D., Special to *The New York Times*, (1965, March 24). Expanded Medicare Bill is Voted by House Panel: House Panel Votes Expanded Medicare, Including Doctor-Bill Coverage. *New York Times*, p. 1. Retrieved January 17, 2009.

Moyers, B. (1964a). Letter from Bill Moyers to Don W. Boston, M.D., October 8, 1964. LBJ Library.

Moyers, B. (1964b). Memo from Bill Moyers to the President, September 2, 1964. LBJ Library.

Moyers, B. (1965a). Memo from Bill Moyers to Lee C. White, April 27, 1965. LBJ Library.

Moyers, B. (1965b). Memo from Bill Moyers to Wilbur J. Cohen, March 1, 1965. LBJ Library.

National Archives and Record Administration (1994). *History White House Health Care Interdepartmental Working Group and Finding Aid*.

National Association of Social Workers (2009). *Social workers in Congress (111th Congress)*. Washington, DC: National Association of Social Workers.

Neustadt, R. E., & May, E. R. (1986). *Thinking in Time: The Uses of History for Decision Makers*. New York: The Free Press.

Nyman, J. A. (2007). American Health Policy: Cracks in the Foundation. *Journal of Health Politics, Policy & Law, 32*(5), 759-783.

O'Brien, L. F. (1963). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, December 5, 1963. LBJ Library.

O'Brien, L. F. (1964a). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson transmitting the Manatos memo of same date, August 14, 1964. LBJ Library.

O'Brien, L. F. (1964b). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, January 27, 1964. LBJ Library.

O'Brien, L. F. (1964c). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, May 11, 1964. LBJ Library.

O'Brien, L. F. (1964d). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, September 2, 1964. LBJ Library.

O'Brien, L. F. (1965a). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, April 8, 1965. LBJ Library.

O'Brien, L. F. (1965b). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, March 2, 1965. LBJ Library.

O'Brien, L. F. (1965c). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, March 9, 1965. LBJ Library.

O'Brien, L. F. (1965d). Memo from Lawrence F. O'Brien to Lyndon Baines Johnson, March 17, 1965. LBJ Library.

O'Brien, L. F. (1974). *No Final Victories: A Life in Politics -- from John F. Kennedy to Watergate*. Garden City, NY: Doubleday & Co., Inc.

O'Brien, L. F. (1985a). Transcript of Lawrence O'Brien Oral History Interview I, 9/18/1985, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1985b). Transcript of Lawrence O'Brien Oral History Interview II, 10/29/1985, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1985c). Transcript of Lawrence O'Brien Oral History Interview III, 10/30/1985, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1985d). Transcript of Lawrence O'Brien Oral History Interview IV, 12/4/1985, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1985e). Transcript of Lawrence O'Brien Oral History Interview V, 12/5/1985, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986a). Transcript of Lawrence O'Brien Oral History Interview IX, 4/9/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986b). Transcript of Lawrence O'Brien Oral History Interview VI, 2/11/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986c). Transcript of Lawrence O'Brien Oral History Interview VII, 2/12/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986d). Transcript of Lawrence O'Brien Oral History Interview VIII, 4/8/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986e). Transcript of Lawrence O'Brien Oral History Interview X, 6/25/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986f). Transcript of Lawrence O'Brien Oral History Interview XI, 7/24/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986g). Transcript of Lawrence O'Brien Oral History Interview XII, 7/25/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986h). Transcript of Lawrence O'Brien Oral History Interview XIII, 9/10/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986i). Transcript of Lawrence O'Brien Oral History Interview XIV, 9/11/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986j). Transcript of Lawrence O'Brien Oral History Interview XV, 11/20/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986k). Transcript of Lawrence O'Brien Oral History Interview XVI, 11/21/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986l). Transcript of Lawrence O'Brien Oral History Interview XVII, 12/17/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1986m). Transcript of Lawrence O'Brien Oral History Interview XVIII, 12/18/1986, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987a). Transcript of Lawrence O'Brien Oral History Interview XIX, 4/22/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987b). Transcript of Lawrence O'Brien Oral History Interview XX, 4/23/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987c). Transcript of Lawrence O'Brien Oral History Interview XXI, 6/18/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987d). Transcript of Lawrence O'Brien Oral History Interview XXII, 6/19/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987e). Transcript of Lawrence O'Brien Oral History Interview XXIII, 7/21/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987f). Transcript of Lawrence O'Brien Oral History Interview XXIV, 7/22/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987g). Transcript of Lawrence O'Brien Oral History Interview XXIX, 11/3/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987h). Transcript of Lawrence O'Brien Oral History Interview XXV, 8/25/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987i). Transcript of Lawrence O'Brien Oral History Interview XXVI, 8/26/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987j). Transcript of Lawrence O'Brien Oral History Interview XXVII, 9/23/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987k). Transcript of Lawrence O'Brien Oral History Interview XXVIII, 9/24/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987l). Transcript of Lawrence O'Brien Oral History Interview XXX, 11/4/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987m). Transcript of Lawrence O'Brien Oral History Interview XXXI, 12/10/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

O'Brien, L. F. (1987n). Transcript of Lawrence O'Brien Oral History Interview XXXII, 12/11/1987, by Michael L. Gillette, Internet Copy, LBJ Library.

Oberlander, J. B. (1995). *Medicare and the American state: The politics of federal health insurance, 1965-1995*. Unpublished Dissertation, Yale University, New Haven.

Office of Congressman Jim McDermott (1993). Fax from Congressman McDermott's office to Richard Veloz, November 3, 1993. Clinton Presidential Library.

Office of the First Lady (1993). First Lady Hillary Rodham Clinton's Daily Schedules. Clinton Presidential Library.

Office of the First Lady (1994). First Lady Hillary Rodham Clinton's Daily Schedules. Clinton Presidential Library.

Office of the White House Press Secretary (1964). Text of the State of the Union Address to be delivered by President Johnson on January 8, 1964. LBJ Library.

Physicians for a National Health Program (2009). AMA's position on single payer - PNHP's official blog. Retrieved April 11, 2009, from Physicians for a National Health Program: http://www.pnhp.org/blog/2008/10/31/ama-position-on-single-payer/.

Pierson, P. (2003). Big, slow-moving, and...invisible: Macrosocial processes in the study of comparative politics. In J. Mahoney & D. Rueschemeyer (Eds.), *Comparative historical analysis in the social sciences* (pp. 177-207). New York: Cambridge University Press.

Pierson, P. (2004). *Politics in time: History, institutions and social analysis*. Princeton, NJ: Princeton University Press.

Poen, M. M. (1979). *Harry S. Truman Versus the Medical Lobby*. Columbia, MO: University of Missouri Press.

Polborn, M. K., Hoy, M., & Sadanand, A. (2004). Advantageous effects of regulatory adverse selection in the life insurance market. *The Economic Journal, 116*(508), 327-354.

ProQuest Historical Newspapers The Los Angeles Times [1881-1986] (2009). Retrieved January 17, 2009: http://proquest.umi.com.ezproxy.lib.utexas.edu/pqdweb?SrchMode=2&sid=11&firstIndex=0&RQT=511&TS=1232261499&clientId=13642&DBId=14075&xsq=TEXT(health%20care)%20AND%20TEXT(aged)%20OR%20(medicare)%20AND%20PDN(%3E11%2F4%2F1964)%20AND%20PDN(%3C7%2F28%2F1965)&xFO=TEXT&xsq1=aged&xFO1=TEXT&xOP1=AND&xsq2=medicare&xFO2=BITXT&xOP2=OR&xsq3=1&xFO3=PAGE&xOP3=AND&saved=1.

ProQuest Historical Newspapers The Los Angeles Times [1986-present] (2009). Retrieved January 17, 2009: http://proquest.umi.com.ezproxy.lib.utexas.edu/pqdweb?RQT=512&querySyntax=PQ&searchInterface=1&SrchMode=2&TS=1233433947&moreOptState=CLOSED&clientId=48776&h_pub_title=&h_pub_title1=&h_pub_title2=&h_pub_title3=&h_pub_title4=&h_pub_title5=&h_pub_title6=&h_pub_title7=&h_pmid=&h_pmid1=&h_pmid2=&h_pmid3=&h_pmid4=&h_pmid5=&h_pmid6=&h_pmid7=&SQ=Clinton&FO=TEXT&OP1=AND&SQ1=health+care&FO1=TEXT&OP2=OR&SQ2=Health+Security+Act&FO2=TEXT&OP3=AND&SQ3=&FO3=CITABS&OP4=AND&SQ4=&FO4=CITABS&OP5=AND&SQ5=&FO5=CITABS&OP6=AND&SQ6=&FO6=CITABS&DBId=603&date=RANGE&onDate=&beforeDate=&afterDate=&fromDate=01%2F20%2F1993&toDate=09%2F26%2F1994&Oppubtitle=AND&pubtitle=&Opsubject=AND&subject=&Opcompany=AND&company=&Opname=AND&name=&Opgeo=AND&geo=&Opsic=AND&sic=&OpAT=AND&AT=any&revType=review&revPos=all&sortby=REVERSE_CHRON&PageSize=10.

ProQuest Historical Newspapers The New York Times [1851-2005] (2009). Retrieved January 17, 2009: http://proquest.umi.com.ezproxy.lib.utexas.edu/pqdweb?SrchMode=2&sid=11&firstIndex=0&RQT=511&TS=1232261499&clientId=13642&DBId=6861&xsq=health%20care&xFO=TEXT&xsq1=aged&xFO1=TEXT&xOP1=AND&xsq2=medicare&xFO2=BITXT&xOP2=OR&xsq3=1&xFO3=PAGE&xOP3=AND&saved=1.

ProQuest Historical Newspapers The Washington Post [1877-1992] (2009). Retrieved January 17, 2009: http://proquest.umi.com.ezproxy.lib.utexas.edu/pqdweb?RQT=512&querySyntax=PQ&searchInterface=1&SrchMode=2&TS=1232261473&moreOptState=CLOSED&clientId=13642&h_pub_title=&h_pub_title1=&h_pub_title2=&h_pub_title3=&h_pub_title4=&h_pub_title5=&h_pub_title6=&h_pub_title7=&h_pmid=&h_pmid1=&h_pmid2=&h_pmid3=&h_pmid4=&h_pmid5=&h_pmid6=&h_pmid7=&SQ=health+care&FO=TEXT&OP1=AND&SQ1=aged&FO1=TEXT&OP2=OR&SQ2=medicare&FO2=BITXT&OP3=AND&SQ3=&FO3=BITXT&OP4=AND&SQ4=&FO4=BITXT&OP5=AND&SQ5=&FO5=BITXT&OP6=AND&SQ6=&FO6=BITXT&DBId=9866&onDate=&beforeDate=&date=RANGE&fromDate=11

%2F4%2F1964&toDate=7%2F28%2F1965&OpAT=AND&AT=any&Opauthor=AND&author=&sortby=CHRON&PageSize=10#more.

Pryor, D. (1993). Letter from David Pryor to Hillary Rodham Clinton, April 26, 1993. Clinton Presidential Library.

Puzzanghera, J., & Oneal, M. (2009). Obama keeps heat on reform agenda; The president seeks to reenergize his policy initiatives in Congress, saying the economic crisis is not over. *Los Angeles Times*, p. A.1. from http://proquest.umi.com/pqdweb?did=1678780281&Fmt=7&clientId=48776&RQT=309&VName=PQD.

Quadagno, J. (2005). *One nation uninsured: Why the U.S. has no national health insurance*. New York: Oxford University Press.

Reckard, E. S. (2009). Some rays of sunshine for the economy; Good news from the retail, banking and foreign trade sectors sends hearts -- and markets -- soaring. *Los Angeles Times*, p. A.1. from http://proquest.umi.com/pqdweb?did=1676611051&Fmt=7&clientId=48776&RQT=309&VName=PQD.

Recording of Telephone Conversation between Clinton Anderson and Lyndon Baines Johnson, September 24, 1964, 8:50 PM, Citation #5688. (1964).

Recording of Telephone Conversation between George Smathers and Lyndon Baines Johnson, September 24, 1964, 5:20 PM, Citation #5673. (1964).

Recording of Telephone Conversation between Hale Boggs and Lyndon Baines Johnson, September 24, 1964, 5:53 PM, Citation #5682. (1964).

Recording of Telephone Conversation between Lyndon B. Johnson, John McCormack, Wilbur Mills, Wilbur Cohen, and Carl Albert, March 23, 1965, 4:54 PM, Citation #7141. (1965).

Recording of Telephone Conversation between Russell Long and Lyndon Baines Johnson, September 24, 1964, 5:30 PM, Citation #5677. (1964).

Rector and Visitors of the University of Virginia (2003). Transcript of tape number 450-23 of a White House meeting between Richard M. Nixon and John Ehrlichman, February 17, 1971. Miller Center of Public Affairs, University of Virginia, Presidential Recordings Program.

Rector and Visitors of the University of Virginia (2009). William J. Clinton Presidential History Project (web site). Miller Center of Public Affairs, University of Virginia, Presidential Oral History Projects.

Reinhardt, U. (Writer) (2009). Keynote Address to Families USA Health Action 2009 National Grassroots Meeting in Washington, DC, January 29-31, 2009. USA: C-Span.

Reischauer, R. D. (1994). Letter from Robert D. Reischauer to George Mitchell, August 9, 1994. Clinton Presidential Library.

Ribicoff, A. (1964a). Copy of Letter from Abe Ribicoff to Clinton Anderson, August 11, 1964 with attachment outlining Ribicoff's "Free Choice Health Plan" alternative to the King-Anderson Bill. LBJ Library.

Ribicoff, A. (1964b). Copy of Letter from Abe Ribicoff to Lyndon Baines Johnson, July 20, 1964, accompanied by cover letter to Lawrence F. O'Brien transmitting the copy, July 20, 1964 LBJ Library.

Ribicoff, A. (1965). Letter from Abe Ribicoff to Lyndon Baines Johnson, March 3, 1965. LBJ Library.

Ricchetti, S., Verveer, M., Jennings, C., & Lew, J. (1993). Memo from Steve Ricchetti, Melanne Verveer, Chris Jennings, and Jack Lew regarding HSA Cosponsors Buffet Breakfast, December 7, 1993. Clinton Presidential Library.

Rice, T., Desmond, K., & Gabel, J. (1990). The Medicare Catastrophic Coverage Act: a post-mortem. *Health Affairs (Project Hope), 9*(3), 75-87.

Rivkin, S. R. (1965). Memo from Steven R. Rivkin to Clifford Alexander, April 21, 1965. LBJ Library.

Rivlin, A. (1993). Statement on the Lewin-VHI Study, December 8, 1993. Clinton Presidential Library.

Roche, C. D. (1965). Memo from Charles D. Roche to Marvin Watson, April 9, 1965. LBJ Library.

Rochon, T. R., & Mazmanian, D. A. (1993). Social Movements and the Policy Process. *Annals of the American Academy of Political and Social Science, 528*, 75-87.

Ross, E. C. (1999). Regulating managed care: Interest group competition for control and behavioral health care. *Journal of Health Politics, Policy & Law, 24*(3), 599.

Rubin, A., & Babbie, E. (2005). *Research Methods for Social Work* (5th Edition ed.). Belmont, CA: Brooks/Cole.

Sabatier, P. A., & Jenkins-Smith, H. C. (1999). The advocacy coalition framework: An assessment. In P. A. Sabatier (Ed.), *Theories of the Policy Process* (pp. 117-168). Boulder, CO: Westview Press.

Sands, D. R. (2009, March 17). Democrats mull end-run for Obama: Unusual rules tactic could trigger partisan brawl. *The Washington Times*, p. B01. from http://www.lexisnexis.com.ezproxy.lib.utexas.edu/us/lnacademic/results/docview/docview.do?docLinkInd=true&risb=21_T6370512199&format=GNBFI&sort=RELEVANCE&startDocNo=1&resultsUrlKey=29_T6370513019&cisb=22_T6370513018&treeMax=true&treeWidth=0&csi=8176&docNo=1.

Schlager, E. (1999). A comparison of frameworks, theories, and models of policy processes. In P. A. Sabatier (Ed.), *Theories of the Policy Process* (pp. 233-260). Boulder, CO: Westview Press.

Schlei, N. A. (1965). Memo from Norbert A. Schlei to Lee C. White, April 6, 1965. LBJ Library.

Schorr, D. (1997). Hillary's second term. *New Leader, 80*(1), 5.

Scofea, L. A. (1994a). The development and growth of employer-provided health insurance. *Monthly Labor Review Online, 117*(3), 3-10. Retrieved from http://www.bls.gov/opub/mlr/1994/03/art1full.pdf.

Scofea, L. A. (1994b). *The development and growth of employer-provided health insurance*. Washington, D.C.: U.S. Department of Labor Bureau of Labor Statistics.

Searle Corporation (1993). RX Partners Response from Searle Corporation. Clinton Presidential Library.

Seib, G. F. (2009). Making sense of a dizzying ride: As president, Obama pursues an ambitious agenda, but some policies face intense debate. *The Wall Street Journal Online*, (April 29). Retrieved from http://online.wsj.com/article/SB124096182151265945.html.

Senate Committee on Aging (1993). Fax of Press Release: CHAIRMAN PRYOR OFFERS BLUEPRINT FOR PHARMACEUTICAL REFORM: Outlines issues and options in discussion paper to Mrs. Clinton, April 26, 1993. Clinton Presidential Library.

Senate Committee on Finance (1993). Press Release regarding Senator Daniel Patrick Moynihan's Introduction of Ammunition Tax Legislation, November 3, 1993. Clinton Presidential Library.

Shaw, D. (1993, November 26, 1993). Biotech holding back on progress: Clinton's health-care plan is cramping this industry's style. *The Philadelphia Inquirer*.

Shepard, A. (2006). Telephone Conversation between Alicia Shepard and David Johnson.

Sisko, A., Truffer, C., Smith, S., Keehan, S., Cylus, J., Poisal, J. A., et al. (2009). Health spending projections through 2018: Recession effects add uncertainty to the outlook. *Health Affairs, 28*(2), w346-w357.

Skocpol, T. (1996). *Boomerang: Health care reform and the turn against government in U.S. politics*. New York: W.W. Norton.

SPSS Inc. (2002). SPSS for Windows (Version 11.5.0).

Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Stake, R., & Kerr, D. (1995). Rene Magritte, constructivism, and the researcher as interpreter. *Educational Theory, 45*(1), 55-61.

Starr, P. (1982). *The social transformation of American medicine*. New York: BasicBooks / HarperCollins Publishers.

Starr, P. (1995). What happened to health care reform? *The American Prospect*(20), 20-31.

Starr, P. (1997). Review of *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics,* by Theda Skocpol. New York: Norton, 1996. *Contemporary Sociology, 26*(2), 150-153.

Steinmo, S., & Watts, J. (1995). It's the institutions, stupid! Why comprehensive national health insurance always fails in America. *Journal of Health Politics, Policy & Law, 20*(2), 329.

Stephens et al. v. CMG Health, et. al. 96 Civ. 7798 (KMW) (United States District Court for the Southern District of New York 1998).

Sullivan, A., & Sheffrin, S. M. (2003). *Economics: Principles in action*. Upper Saddle River, NJ: Pearson Prentice Hall.

Tanouye, E. (1993, March 11). Drug prices get dose of market pressure. *Wall Street Journal*.

The Gallup Organization (1962). The Gallup Poll #662 Field Date 08/23/1962-08/28/1962, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1963). The Gallup Poll #677 Field Date 09/10/1963-09/10/1963, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1964a). The Gallup Poll #688 Field Date 03/27/1964-04/02/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964b). The Gallup Poll #689 Field Date 04/24/1964-04/29/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964c). The Gallup Poll #694 Field Date 06/25/1964-06/30/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964d). The Gallup Poll #695 Field Date 07/21/1964-07/21/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964e). The Gallup Poll #696 Field Date 08/04/1964-08/04/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964f). The Gallup Poll #697 Field Date 08/25/1964-08/25/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1964g). The Gallup Poll #699 Field Date 10/08/1964-10/13/1964, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1965a). The Gallup Poll #706 Field Date 02/19/1965-02/24/1965, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1965b). The Gallup Poll #708 Field Date 03/16/1965-03/16/1965, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1965c). The Gallup Poll Field Date 05/13/1965-05/18/1965, Most Important Problem Question. Retrieved July 11, 2008, from The Gallup Organization:

The Gallup Organization (1992a). The Gallup Poll March 1992 Field Date 03/26/1992-03/29/1992, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1992b). The Gallup Poll May Wave 1 Field Date 05/07/1992-05/10/1992, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1992c). The Gallup Poll Town Meeting Study Field Date 08/28/1992-09/02/1992, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1993a). The Gallup Poll January Wave 1 Field Date 01/08/1993-01/11/1993, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1993b). The Gallup Poll September Wave 1 Field Date 09/10/1993-09/12/1993, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1994a). The Gallup Poll August Wave 2 Field Date 08/15/1994-08/16/1994. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1994b). The Gallup Poll Clinton Report Card #6 Field Date 07/15/1994-07/17/1994, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1994c). The Gallup Poll January Wave 2 Field Date 01/28/1994-01/30/1994, Most Important Problem Question. Retrieved July 1, 2008, from The Gallup Organization:

The Gallup Organization (1994d). The Gallup Poll Labor Day Benchmark Field Date 09/06/1994-09/07/1994. Retrieved July 1, 2008, from The Gallup Organization:

The Lasker Foundation (2008). About The Foundation: The Lasker Legacy Retrieved January 24, 2009, from http://www.laskerfoundation.org/about/legacy.htm.

The National Coalition on Health Care (2007). *Health Insurance Cost*. Washington, DC: The National Coalition on Health Care.

The White House (2009). The Agenda: Health Care Retrieved January 26, 2009, from http://www.whitehouse.gov/agenda/health_care/.

Tilley, K. (1993). Memo from Kim Tilley to Hillary Rodham Clinton, June 12, 1993. Clinton Presidential Library.

Transcript of the President's First Report to Congress on the State of the Union (1961, January 31). *New York Times*, p. 16. Retrieved January 7, 2009.

Transcript of the President's Message to Congress on the State of the Union (1965, January 5). *New York Times*, p. 16. Retrieved January 15, 2009.

U.S. Census Bureau (2006). Historical Health Insurance Tables HI-9. Washington, DC: U.S. Census Bureau.

U.S. Census Bureau (2007a). Annual Social and Economic Supplement - Table HI02. Washington, DC: U.S. Census Bureau.

U.S. Census Bureau (2007b). Annual Social and Economic Supplement - Table HI03. Washington, DC: U.S. Census Bureau.

U.S. Census Bureau (2007c). Historical Income Tables - Households. Retrieved September 13, 2007, from Washington, D.C.: U.S. Census Bureau: http://www.census.gov/hhes/www/income/histinc/h02ar.html.

Hearings on Unemployment Insurance Amendments, U.S. Congress, 85th Cong., 2nd Sess. (1958).

U.S. Department of Health and Human Services: Centers for Medicare and Medicaid Services (2007). *National Health Expenditure Data*. Washington, D.C.: U.S. Department of Health and Human Services.

U.S. House of Representatives Committee on Ways and Means (1965). Committee print of press release titled "Summary of Decision of Committee on Ways and Means, U.S. House of Representatives, on Health Insurance for the Aged, Medical Care for Needy, Social Security Benefit Increases, Social Security Coverage Changes, Public Assistance Amendments, Etc. . LBJ Library.

United Press International (1964). Wire service message by UPI concerning testimony of Joe Belden, a Dallas public opinion pollster, January 22, 1964. LBJ Library.

United States Department of Commerce Bureau of the Census (2008). Statistical Abstract of the United States Table 144. Health Maintenance Organizations (HMOs): 1990 to 2006. Retrieved April 30, 2009, from United States Department of Commerce Bureau of the Census: http://www.census.gov/compendia/statab/2008/tables/08s0144.pdf.

Valenti, J. (1964). Handwritten Note from Jack Valenti to Lyndon Baines Johnson transmitting Ribicoff Letter, July 20, 1964. LBJ Library.

Valenti, J. (1965a). Memo from Jack Valenti to Lyndon Baines Johnson, April 22, 1965, with handwritten note from Johnson back to Valenti. LBJ Library.

Valenti, J. (1965b). Memo from Jack Valenti to Lyndon Baines Johnson, June 23, 1965. LBJ Library.

Valenti, J. (1965c). Memo from Jack Valenti to Lyndon Baines Johnson, March 6, 1965, with handwritten note from Johnson back to Valenti. LBJ Library.

Valenti, J. (1965d). Memo from Jack Valenti to Wilbur J. Cohen, March 3, 1965. LBJ Library.

Weathers, K. G. (2004). *Fitting an elephant through a keyhole: America's struggle with national health insurance in the twentieth century.* Unpublished Dissertation, University of Houston, Houston, TX.

White House Office of the Press Secretary (1993a). Attendees at Today's Health Care Reform Supporters Event and Letters of Support for the President's Health Care Plan, Press Release, September 23, 1993. Clinton Presidential Library.

White House Office of the Press Secretary (1993b). Press Briefing by Secretary of the Treasury Lloyd Bentsen and Director of OMB Leon Panetta, December 9, 1993. Clinton Presidential Library.

White House Office of the Press Secretary (1994). Statement by Dee Dee Myers in response to Elizabeth McCaughey's article entitled "*No Exit: What the Clinton Plan Will Do For You"* in the New Republic, January 31, 1994. Clinton Presidential Library.

White, L. C. (1965). Memo from Lee C. White to Lyndon Baines Johnson, April 26, 1965. LBJ Library.

Wickenden, E. (1965). Letter from Elizabeth Wickenden to Jack Valenti, May 28, 1965. LBJ Library.

Wilson, H. H. (1973). Transcript of Henry Hall Wilson Oral History Interview, 4/11/1973, by Joe B. Frantz, LBJ Library.

Winfield, B. H. (1997). The making of an image: Hillary Rodham Clinton and American journalist. *Political Communication*, p. 241. from http://ezproxy.lib.utexas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ufh&AN=9707011764&site=ehost-live.

Woolley, J. T., & Peters, G. (2007). The American Presidency Project [online]. Retrieved September 13, 2007, from Santa Barbara, CA: University of California [hosted], Gerhard Peters (database). Available from World Wide Web: http://www.presidency.ucsb.edu/ws/?pid=26985.

Working Group on Pharmaceutical Access and Cost Containment (1993). Briefing Book for the President and the First Lady. Clinton Presidential Library.

Wright, Z. (1974). Transcript of Zephyr Wright Oral History Interview, 12/5/1974, by Michael L. Gillette, LBJ Library.

Yager, M. (1993). Memo from Marilyn Yager to Ira Magaziner, Caren Wilcox, Amy Zisook, Chris Jennings, Mike Lux, Marilyn DiGiacobbe, and Jonathon Silver, September 1, 1993. Clinton Presidential Library.

Vita

David Howard Johnson attended Sullivan Central High School in Blountville, Tennessee. In 1974, he entered the University of Tennessee at Knoxville. In the summers of 1975 and 1976, he attended East Tennessee State University in Johnson City, Tennessee. He received the degree of Bachelor of Music from Mars Hill College in Mars Hill, North Carolina in August, 1979. During the following years, he was employed as a high school band and choral director and in a variety of management and executive positions in the life and health insurance industry, the medical device industry, the real estate industry, and the Internet industry. Subsequent to receiving his Bachelor of Music degree, he briefly attended Western Carolina University in Cullowhee, North Carolina and the University of North Carolina at Asheville. He received the Master of Social Work degree from the University of Southern Mississippi in Hattiesburg, Mississippi in May, 2005. In August, 2005, he entered the Graduate School at The University of Texas at Austin. He joins the faculty of Millersville University of Pennsylvania in the Fall of 2009 as an Assistant Professor in the School of Social Work.

Permanent Address: 675 Wyncroft Lane #5, Lancaster, Pennsylvania 17603

This manuscript was typed by the author.